STEVEN SANET, D.O.

A POUND OF CURE

REAL LIFE EXPERIENCES OF AN OSTEOPATH

Foreword by Dr. Krishna N. Sharma

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ISBN-13: 978-1508757061
ISBN-10: 1508757062

DEDICATION

I would like to dedicate this book to my wife Zipporah and my sons Nathan and Louis for allowing me to pursue my passion, through all the late nights, extensive traveling, and my mood swings in the process. Without their love, this work would have remained unsung.

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ACKNOWLEDGMENTS

Everything wise I have become I learned under the mentorship of my father; my development has always been watered by the love of mother and father.

I wish to thank Margaret Connolly, without whose insistence on putting fingertips to keyboard and editorial skill this story would have remained a few megabytes of discontinuity on my computer. Her knowledge of osteopathy and of my sentiments made this publication possible.

FOREWORD

Being a medical professional I can tell you that a medico always has lot of real stories. We learn and experience something new every day.

This book by the greatest osteopath I have ever known personally is his journey of his professional career. It is a compilation of his experiences in the field of Osteopathy.

Apart from being an answer to the questions of new osteopaths who want to know how did Steve – a famous name who teaches this skill in more than 40 countries sharpened his abilities; this book also serves as a hope to the patients who are under the influence of "Nothing can be done" and/or "Let's see what happens". This book teaches to be positive and proves that the miracles can happen anytime.

I hope you will like this book just like me and it will help you understand the strength of Osteopathy.

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A Note on the Text

In these stories, patients' names have been changed to protect their privacy, but no details of their cases have been changed, because this is a book of non-fiction, not fiction. This is the reality of my practice as I have experienced it. Sometimes I have omitted identifying characteristics, and occasionally I have changed the sex of the patient, again to protect privacy, but otherwise I have not invented any facts of the patient's biography. In a few situations I have used the full names of colleagues, with their permission as appropriate. Otherwise, when only a first name is used, the name is not the person's real name.

Introduction

I am writing this book because I have an inside view of medicine and healing that can change people's lives. I've witnessed lots of bad medicine and lots of miracles, and learned far more from my patients than I did in medical school. I have all kinds of patients, but I really like to work with people who haven't been helped by conventional medicine: the ones with failed back surgeries, with migraines that won't go away, with mysterious illnesses that nobody knows what they are and nobody's been able to help—yet.

I typically tell patients that within a few visits, I will either fix your problem or make a significant difference such that you will know it makes sense to continue working together. If after a few visits I haven't helped you, then I'm not the guy for the job. I have more requests for appointments than I can accommodate. Why do I get these results?

The kind of medicine I practice is known as osteopathic medicine, a form of treatment that activates the body's ability to heal itself. In the United States, where I had my training and began my practice, there are two types of fully licensed physicians, osteopathic physicians (D.O.) and allopathic physicians (M.D.). Unfortunately, today there is in practice not much difference between the two. Osteopathy has been absorbed into the conventional medical system, which allows very little time to evaluate and treat a patient. Many contemporary D.O.'s practice just as M.D.'s do, by prescribing medication for every ailment as a first line of defense.

Osteopathy began over a hundred years ago,

in the last decades of the nineteenth century. It was founded by an M.D. named Andrew Taylor Still. Dr. Still had lost his children to meningitis, and he believed that the medicines of his day were either poisonous or useless. For the most part, this was certainly true. He developed a new style of medicine, which bases healing on restoring the body's natural healing mechanisms. He did this by using manipulation to augment blood flow and lymphatic flow, to restore motion to impaired joints, and to release restrictions in the internal organs and the fascia (sheets of connective tissue that run throughout the body).

Don't get me wrong, I'm not an anti-medicine doctor. I don't oppose the use of drugs or surgery out of hand. I prescribe medicine for my patients when I feel it's appropriate and I refer patients to surgeons when necessary. But it's no secret in our society that drugs and surgery are used way too much; that drugs usually have so-called "side" effects, some of which can be very problematic, even lethal; and that surgery fails often enough and can also create further problems of its own. One of the beauties of osteopathy—when it's practiced by someone who's highly knowledgeable about the body and highly skilled in the use of manipulation—is that such unwanted consequences are rare indeed. And that is because osteopathic manipulation, when done correctly, simply mobilizes the body's own healing capacities.

For a few decades, osteopathic medicine fell into eclipse as allopathic medicine (conventional M.D. medicine) became, and continues to be, America's dominant mode of medical practice. But we are in a time of change. The public is well aware of the

limitations inherent in the allopathic approach to treatment. Antibiotic-resistant bacteria are a growing threat. Many have theorized that antibiotic medicines will be useless in ten years because of bacterial resistance to these medicines. We make stronger drugs and the bugs get stronger in return. So many chronic illnesses either don't respond at all or respond poorly to drugs. And despite radio ads directed to "people who need prescription medicine to stay healthy," the public is not so dumb. The public understands that anyone who needs prescription medicine is not healthy: drugs do not create health. People want a change. At the same time a rising generation of osteopaths and their colleagues in related fields are intent on reclaiming osteopathy's potential for healing.

In this book I'll tell you the story of how I discovered osteopathy while I was already a medical student, what I learned from my patients over the years, how I founded a center for osteopathic teaching and treatment, and how I reached the point where I'm helping to train the next generation of osteopathic practitioners and our colleagues in related fields in North America, Europe, the Middle East, and Asia. In the process I may reveal what many people possibly suspect, that physicians are not gods.

Along the way, I'll tell you many stories of healing. I'll give you some idea of the how's and why's of osteopathy. For anyone who wants a high level of wellness; for anyone who wants care that fulfills the ancient physician's principle "first do no harm"; for health-care professionals who want to learn a safe and effective way of helping patients; and for patients who still suffer despite years of medical treatment, it is my passionate desire to offer a special

gift: the gift of hope and some knowledge about how to proceed. There *is* a better way.

How I Discovered Osteopathy

I had worked my ass off getting to med school. I completed a four-year undergraduate degree in two and a half years while working full-time to support my wife and two kids. I graduated summa cum laude, Phi Beta Kappa, top of my class. So naturally when I got to med school I thought, "race car driver, astronaut, brain surgeon; that's it! I'm going to be a brain surgeon, they're really smart and they make a shitload of money."

I can't say that I was drawn to osteopathic school versus allopathic school because I wanted to be an osteopath. It was just another route toward becoming a physician. I had gone to the admissions office of the two most prestigious local medical schools while I was still in college, and they said great, glad to have you, finish your undergraduate degree and come back. But the osteopathic school was willing to take me right then, and my college was willing to work a deal where my first year of medical school credits would count toward completing my undergraduate degree. I didn't want to give another year of my life to undergraduate work, so I chose the osteopathic school.

In the early nineties I went to a medical convention in Dallas, Texas and met Dr. Robert Fulford. A friend told me that he was the best in our profession and that this is someone I should meet. Meeting him changed everything. I watched him demonstrate on a friend of mine. My friend had a twisted knee—something that we could all look at and agree upon.

Dr. Fulford worked on my friend's abdomen—never laid a hand on his knee. When he was finished, the twist was gone. Dr. Fulford talked about the mechanisms involved, he talked about fascia—the soft connective tissue that runs throughout the body—and he talked about energy, emotions, spirit. This is the same Dr. Fulford that Dr. Andrew Weil has written of in his book *Spontaneous Healing* and in his introduction to *Dr. Fulford's Touch of Life.*

I left that meeting knowing what I wanted to do. I didn't know how I would make a living at it, but I knew what would be my path. Whatever it was that I had just witnessed, I wanted to learn how to do it. I phoned my mom in Philadelphia and told her what I had seen

and what I wanted to do and she hesitated, then said, "Well, your father and I kind of thought after all of this…you were going to be a regular doctor." I said, "I am going to be a doctor, but this is the kind of work I want to do." My mom said, "But……we thought, you know……you were going to be a regular doctor, what if we get sick?" I said, "Don't worry, I have lots of friends who are regular doctors, you can see one of them." The reality is that my parents have become some of my best promoters and I do a little general family medicine in my practice.

Knowing Where to Look

I was a medical student on rotation at a busy family practice center and I had just finished a course in organ manipulation. My first patient was a forty-some-year-old overweight lady who was getting treated several times a week for injuries sustained in an auto accident.

Her main complaint was right shoulder pain and restricted movement of her right arm. She had been through all of the more standard physical therapy regimens, heat therapy, cold therapy, ultrasound, massage, range of motion exercises, and more.

Usually, where shoulder problems, pain, and immobility are concerned, therapists examine all of the muscles in and around the various shoulder joints as well as the joints themselves. I thought I would try a different approach.

First I did an exam. As a diagnostic procedure, I raised her right arm until she told me it hurt. I got her arm up at about ninety degrees straight out from her side. I then put some gentle pressure against her right lower ribcage and repeated the same test, again with her right arm. This time she was able to raise her arm all the way over her head, without pain. How come?

Well, when I put gentle pressure against her ribcage, it allowed more movement from the ligaments that suspend the liver in the abdomen. With reduced ligamentous tension, she was able to have greater motion in her thorax, which resulted in greater motion of her arm. Am I suggesting that her liver is the cause of her shoulder problem? No. But we may use the structures within the thorax and abdomen, such as the liver and ligaments, to affect the right arm and shoulder. This is an osteopathic whole-body approach to a right-shoulder problem, rather than looking at just the right shoulder. Now that I had made my diagnosis, with further manipulative techniques I was able to provide this woman with lasting relief from pain.

Burying the Dead

Early on, during my third year as a medical student, I learned that physical pain often has an emotional underlying cause. In my neighborhood there was a guy whose son had gotten a strep throat. The strep throat got complicated, the son was hospitalized, and over a two-week period every organ system failed and the child died.

It was the kind of thing that everyone in the neighborhood was talking about. You felt more and more horrible with each new bit of news. What's more, the boy was the oldest son, four years old, and his father was a physician.

Anyway, although I had heard all about the case I didn't realize that this boy's father was my patient. His name was not that unusual. I treated the physician for neck injuries he'd sustained in an accident. I felt that by this time I was pretty good at manipulation. Although I was still a student, I had a special fellowship year in which to concentrate on osteopathic manipulative medicine (OMM). I did everything I knew how to do, and on the follow-up visit he was really no better. I knew that whatever it was, I wasn't able to help.

I asked a friend of mine to see if he could help. My friend, Victor, was an M.D. who was visiting our school for a year to learn manipulation. He had just finished a course in emotional and physical work. Victor told me that he did not want to know the patient's history. He wanted to treat him without knowing what had happened or what his complaint was.

Without talking, Victor began to do a technique known as unwinding. He moved different body parts, arms, legs, torso, and head until he felt some sort of stopping sensation or end point. When Victor was finished unwinding, the patient was seated on the table with his right leg extended, his foot pressed down, his left elbow bent, his left hand towards the ceiling, and his head turned to the left.

Victor asked him one question, "What are you thinking about?" to which he replied, "I was remembering my son that I buried four months ago." That was it! He had been driving his car, right foot on the gas pedal, left arm out the window, left hand holding the window

frame, and looking to the left, thinking about the burial of his deceased son, when his car slammed into a telephone pole.

His neck hurt because he'd had a car accident. But the reason that it continued to hurt was because the memory of this body position became locked into his tissues from the heavy emotional content present at the time the physical force hit him. Victor identified this connection for him. After that treatment, I did further work on the patient, and the rest of his physical problems resolved with the same type of treatment I had tried before.

I have since confirmed this type of experience many times in the course of my practice. It is regarded as a common phenomenon among many practitioners of hands-on treatment, and sometimes the term "tissue memory" is used to describe it. Some people might argue whether or not your soft tissues are capable of storing memories of events in your life. Possibly the word "memory" is not the most useful word to use in this connection. Maybe the word "memory" sends our thoughts in the wrong direction, and a word such as "imprint" would leave us more open to investigating what the phenomenon actually is. In the meantime, the following kind of analogy has been made, and many find it useful: You can watch your favorite movie or listen to your favorite music on a piece of magnetized plastic that we know as a DVD or a cassette tape. Does it seem possible that your body is less sophisticated than a piece of plastic?

Your body is a proprioceptive recorder for all of your life's experiences. Every joyous moment, every tragedy leaves its mark in your mind as well as in various tissues and organs of your body.

Total Body Failure

When I was a fourth-year medical student, I was working in a clinic where there were usually two or three other doctors present. One of my professors had gotten me the job to work on Saturdays. The group saw a lot of injury cases and so did a lot of musculoskeletal work. I would get tossed the patients with back and neck pain. One day I was asked to treat a woman who had been in a car accident. We'll call her Brenda.

I asked my boss, "Well, what's wrong with her, what do you want me to do?" My boss said, "She's got T.B.F." "T.B.F., what's that?" I asked. "Total Body Failure. Do whatever you want." I have since heard many more terms to describe the same thing: "supratentorial," "hypochondriacal," and others. "Hypochondriacal" is a term most people understand. "Supratentorial," for those familiar with medical terminology, would refer to the area above the tentorium, a layer of tissue that lies underneath the cerebral hemispheres of the brain. In other words, the term is used dismissively: the patient's problem is all in his or her head, psychological, not important.

So what all these words really mean is that the patient is complaining constantly to their doctor. Generally speaking, doctors aren't interested in repeat business; they want you to come with a complaint, fix it with a pill or cut it out of you, and never hear from you again.

Anyway, that aside, I was asked to treat this woman who my boss felt was an incessant complainer. "Well, so where does it hurt, what's bothering you?" The reply was long: headache, back pain, neck pain, everywhere pain. So I decided that I would do some very gentle intra-oral techniques to treat her headache. I did this and her head felt a little better.

I saw her the following Saturday. Back to square one, everything hurts. So I decided, to hell with it, I'll do whatever I want. I figured that it was too complicated to ask her what I should work on and so I just started to unwind her legs. The unwinding technique is based on the fact that restrictions accumulate in the sheets of connective tissue within the body called fascia. These restrictions can

cause both pain and dysfunction. To unwind the restrictions, you gently move the limbs along fascial stress planes until release is felt.

I did this for about five minutes. I started feeling tension mounting, subtly. Something was coming, something big. I continued to unwind her legs until she was lying on her back with both legs and knees bent into a frog-leg position, similar to a position common for childbirth or a missionary position for love-making. As I felt the tension reach crescendo, she let out a blood-curdling scream. Then she screamed some more. She kept screaming. It felt like she was screaming for an hour, but in actuality it was probably about three or four minutes. That was long enough.

On an intellectual level, I thought this was good. This was the deep release that was needed to get her healing. On a very human level, I thought "Shit, I gotta get outta here, she's flipped out." But my first thought was correct.

On a humorous note, during the height of the screaming, my boss came in under the pretense of looking for some tool in the drawers. He was checking to see if I was torturing her, pulling her thumbnails off or something, to account for the noise. He looked scared.

I was definitely scared. I remember one of my mentors telling me that these big releases wouldn't come up unless I was going to be able to handle it. Be that as it may, it still scared the crap out of me.

After she was done screaming, she sobbed softly for another twenty minutes. Then she recounted, in vivid detail, how she had been raped some twenty years ago. Previously, Brenda had been to the clinic three times a week forever without getting better. I didn't see her the following Saturday, or the next, or the next. She stopped in at the clinic the following month, gave me a big hug, and told me that she was finally moving forward with her life.

What happened? She had had extensive therapy regarding being raped, she had had extensive therapy for her aches and pains, but until now she hadn't made a connection between the memories in her mind and the pain in her body. Now the osteopathic treatment had made the connection for her. Her aches and pain became minor

and no longer held her back in her life.

Migraine

As a student I very quickly became known as the guy to see for pain, all kinds of pain. I treated a guy for severe back pain and he asked if I could help his wife, Carol. Carol was thirty-eight years old and had been suffering with daily crushing migraine headaches for over a year and a half.

A year and a half earlier, a five-hundred pound cabinet had fallen over and a drawer had opened up and crushed her face and jaw. She had had several reconstructive surgeries. Her jaw was still held in place with wires and she was living on a highly addictive barbiturate for pain relief (Fiorinal), which didn't relieve her pain anyway.

I treated her once. I released her jaw with gentle cranial techniques, loosened the suspensory fascia under her jaw in the region of her hyoid bone, and used myofascial technique to ease the tension on the back of her head. She cancelled her follow-up appointment because it was a two-hour drive to the clinic one-way...and she had no more pain. While still a student, I would hear from Carol and her husband at holidays to let me know they were doing fine.

More Isn't Always Better

Again while still a student, I was treating a man in his late thirties for excruciating back pain. He was in a bind. He was an illegal alien, Hispanic, trying to support his family. He didn't have the luxury of taking time off till he felt better. All that aside, I did my best. I treated him and saw him on follow-up two days later. He was doing okay and was back to work. I told him that I would see him in two weeks and I expected that he should be fine.

Well, the following week I was on hospital rounds and I was told that he was in severe pain and was on his way to see me immediately. What had gone wrong? I figured that perhaps he was just working too hard or hadn't taken it easy as I'd suggested.

I looked at him. He looked like he just lost a fight with King Kong. He was unable to stand up straight and he had pain in his eyes. I took his shirt off. I had my answer in two seconds. His back was as red as a lobster.

What had happened was that another doctor had sent him to the hospital three times a week for ultrasound treatments for his back. I was pissed off. I had taken care of him appropriately, and he was doing well, and in the interests of making a couple more bucks, he was sent for unnecessary treatment. What started as an acute muscle strain and spasm was replaced with a nice deep burn and destruction of muscle tissue that would take at least a month to heal.

Sometimes people feel that more is better. If two aspirin help a headache, then four would be twice as good, and eight would be four times better. The reality is that two are good for a headache and eight will burn a hole in your stomach.

Nicaraguans

One of my mentors had told me, "Steve, if you want to be a better doctor, you have to stop listening to the patient." What he meant was to stop listening to what the patient said the problem was and listen to the information that the patient's body told my hands. That sounds like great advice, but putting it into practice was quite another matter indeed. My teacher was telling me that I shouldn't let myself be prejudiced by the patient's words before I began my examination. The way to do this was to palpate, make a diagnosis, and only then talk to the patient.

I decided that with the next patient I was going to try this. My next patient was a fifty-year-old Nicaraguan male. I told the medical assistant that I did not want to know what his complaint was. This was easy because he only spoke Spanish, so there was no chance of him ruining my whole plan by talking to me during his examination. His fifteen-year-old son was there as a translator. I told his son that I wanted to examine him first and then I would hear his father's story afterward.

I did various craniosacral and visceral techniques to make my diagnosis. This took me about thirty to forty seconds, and I describe the process later in this book. I told his son that I felt his main problem was his third lumbar vertebrae in his lower back. He translated this to his father. His father told me (via our translator, his son) that his back felt fine, it was his knee that hurt. I reiterated that I felt his lumbar vertebra was my first priority and that I wanted to treat only that aspect today and check his progress in a couple of days.

Well, an argument broke out between the man and his son. My spanglish was not too good at the time. However, I did know what an "idioto!" was and I knew that he was referring to me. I insisted that he indulge me. I told him that his problem had already been looked at by a myriad of doctors and no one was able to help, so what did he have to lose? And what if I wasn't able to help? Twenty other distinguished doctors had failed, so I would be in good company.

He let me go ahead. I treated only his third lumbar vertebra,

and subjectively 75% of his knee pain went away. I say "subjectively" because pain is a subjective experience: more on this later. A few days later I did some minor manipulations to his fibula (a lower leg bone) and his problem was fixed.

How can a third lumbar vertebra affect a knee? It goes like this: at every level of your spine, various nerves exit on either side, going to the front and back and giving nerve supply to different areas of the body. The nerves that supply your knee joint and associated ligamentous structures originate from the third lumbar vertebra. This mapping of ligamentous structures and their corresponding vertebral origins is known as a sclerotome.

Does that mean that I examine the third lumbar vertebra for everyone with a complaint of knee pain? No. There are many possible reasons for pain in any given area; a sclerotomal distribution is only one reason. So how important is it for a patient to tell me that his knee hurts? Answer: It is totally irrelevant to my diagnosis or to my treatment plan. But it is relevant to measure his progress. Why?

Because pain is a big fat liar. What do I mean by that? Remember I said that pain is a subjective experience. What that means is this: two people with the exact same physical problem can have totally different experiences in intensity of their pain, location of their pain, and how pain has affected their life. It is subjective; it is their experience. For me, pain does not narrow the field of what might be wrong. It does not tell me where to proceed. That is why I elect to treat whatever does not feel right to me. In the conventional terminology of the medical profession, what I find when I examine the patient is objective. If tissue feels tense, ropy, boggy, or misaligned, then quite simply it needs to be treated to restore normal function, regardless of what the patient's complaint is.

So I treat what I find, not what a patient verbalizes. Is their opinion meaningless? No, it's very meaningful. I will treat what I find and measure my success by a resolution to their pain: the reason they came in to see me in the first place.

Irritable Bowel Syndrome

It so happened that the patient's son, the fifteen-year-old boy, was constantly in the clinic. I asked my boss (the attending physician, since I was a med student), why he was here, what was wrong with him? My boss told me, "he's a psych case." What this generally means is if the problem isn't readily solvable, medically, then the problem must be bullshit.

The patient's history revealed a handsome teenage Nicaraguan boy who had had bowel urgency and frequency for more than nine months and was diagnosed with irritable bowel syndrome. Translation: here was a young man who should be going to the movies on dates but was unable to because at any moment he might poop his pants.

I told my boss that I wanted to treat him. He said, "Go ahead, but you're wasting your time." In subsequent years, I have found irritable bowel to be a condition that is quite amenable to deep organ manipulation, but this was my first time treating this type of problem. I treated this young man and saw him six days later.

Such a smile he had on his face, I will never forget it. He told me that he had had completely normal bowel function for five days and that, today, he began to have loose stool. For five days he had not had to run to the bathroom. For five days he had not had to worry about suddenly having an accident in his pants. For five days he was a normal teenage boy. I treated him again on that sixth day and then he and his family returned to Nicaragua and I never saw him again.

As I said, since this first case of irritable bowel syndrome I have confirmed that the condition is readily treatable with manipulative techniques. Another case that comes to mind is that of Deirdre, who came to me complaining of her dependence on Imodium to control her diarrhea. She said, "I just want to be free from having to live on drugs to keep from having to run to the bathroom." On examination, her belly was extremely sore to the mildest touch.

I've never seen anyone complaining of irritable bowel who didn't have multiple tender areas of their abdomen. With the use of

gentle pressure over her belly, her diarrhea stopped. The bowel is composed of smooth muscle that is involuntary in nature. This smooth muscle is subject to the same stresses and strains as skeletal muscle. When the bowel is too weak, we tend toward constipation; when it is hyperactive, we tend to have diarrhea. I used focused pressure about key areas on her abdomen to stimulate the smooth muscles and allow discharge of accumulated stress, thereby causing both relaxation and proper contractility of the bowel.

When I saw her for follow-up, she was smiling, bright, and Imodium-free. Free at last after years of worry, years of dependence on medication, years of worry over where to plan bathroom stops. When she stopped using Imodium, I'm sure the pharmaceutical stock must have plummeted. Now Deirdre has better things to do than plan her day around stomach pain and diarrhea.

Expression

I have found that of all of the possibly sensitive areas of the body, the mouth seems to hold the most emotion. Oftentimes it is easier to work on someone's pelvis than it is to stick a finger in their mouth. The mouth is an area where people tend to literally "choke down" a lot of what they don't express. Let me give some examples.

I once treated a guy for irritable bowel syndrome. I treated him maybe four or five times with deep abdominal manipulation, which worked for several months before his symptoms returned—diarrhea and stomach pain. He asked me why his symptoms returned when he could think of nothing else changing in his life to account for this. He was a young, successful stockbroker who seemed to have everything he wanted.

When problems are fixed physically but the complaint persists, I look for an emotional underlying cause. I suspected that there was some emotional event associated with this patient's irritable bowel complaints. He denied this. I said that if he wanted to look for a deeper cause, I would need to do some work in his mouth. This usually consists of mild to moderate finger pressure in the roof and the floor of the mouth. He agreed. As I began to release the tissues in the floor of his mouth, tears began to roll down his face.

I asked him what he was thinking about, he said "nothin'." I asked him if I was hurting him, he said "no." I asked him if he usually cried while he was being treated, he said "no." Afterward, he said he felt fine and didn't think that he would need any more treatment, thanked me, and left.

You can lead a horse to water, and that's it. I believe that he wasn't ready to look deeper as to an emotional cause of his irritable bowel. He saw or felt or remembered something when his jaw was released. He either didn't want to look at it or he was not ready to share what he felt.

If emotions are suppressed, then they will manifest elsewhere but definitely somewhere in the body. Since our voice is our conscious way of interacting with others, suppression here often tightens the tissues around the hyoid bone just below the jaw and

tissue within the floor of the mouth.

A phenomenon I have observed more often than not is that when these tissues are released, the patient usually loses the ability to hold back or suppress their feelings for about twenty-four to forty-eight hours. So I give them a warning in case they go home and get in an argument that would have been avoided had they "held their tongue."

While I want to caution them against getting into an argument that otherwise might not have happened, I don't mean for them to avoid expressing themselves or to suppress the issues they need to discuss. I have also considered that my suggestions might create a self-fulfilling prophecy: that because I tell patients they might express themselves more, they will. So I also tell them that this is not a post-hypnotic or post-treatment suggestion but an observation. That's the disclaimer I tell patients when I release these areas.

This too is a phenomenon I've confirmed in later years of practice. This technique for releasing the mouth works for professors, bankers, stockbrokers, lawyers, cops, and more. Ellen was a college professor who had a lively e-mail correspondence with her colleagues. The day after I had released her mouth, she realized that she was writing enormously long e-mail messages. They weren't explosive or confrontational, but she recognized that she was "chattering away" at much greater length than usual. Then there's Frank. Frank is an officer in the military, one of the most pragmatic, clear-thinking people I know. The day after I had released his mouth, he returned to Berlin and had the biggest argument over something very trivial with his commanding officer. When we spoke about it, I asked him, "What was the particular fight about?" He said that it wasn't about anything in particular, but he was feeling the release of tension that had been built up for a long time and he just let it out.

Husbands, wives, parents, children, friends, good guys, bad guys, we all have things we haven't expressed. After time, the lack of expression deposits somewhere in the body. What doesn't work its way out of the body works its way deeper into the body.

"I Feel So Good, I Feel Like I Cheated on My Husband"

When I was a senior medical student on rotations, I had a reputation for being the guy to fix people when they weren't getting anywhere. I was asked to see a woman in her early forties who had been treated for bronchitis for more than six months. She had been treated with a whole slew of antibiotics without result.

I used everything in my arsenal to activate her body's natural healing and restorative mechanisms. I used myofascial techniques to loosen the achy muscles over the back of her chest, achy from constant coughing. I also needed to do this to restore full motion to her ribs; full rib motion would help to facilitate sympathetic nerve stimulation and help restore balance to the autonomic nervous system. I used cross-fiber stretching to open her lymphatic channels and to cause a siphon on the lymphatic system to drain extracellular fluid. I used cranial techniques to promote sinus drainage. I used myofascial techniques to stretch her linea alba (the thick band of fascial tissue that runs from the breastbone to the pubic bone) and increase her diaphragmatic excursion. This means that when she breathed, her diaphragm would be moving a lot more freely. Among other things, the increased motion would help lymphatic drainage—one way the body gets rid of garbage and moves necessary fluids that are not transported in the bloodstream.

I had given her my all. I hoped that she would be feeling better. At the end of my treatment, my boss came in to check on my progress. He said, in his own cocky way, "Well, hon, how're you feelin'?" And she said, "I feel so good, I feel like I just cheated on my husband." I'm sure that I turned totally pink in the face when she made this declaration, although I was quite pleased with myself to elicit that kind of response.

His Back Was Better, But His Life Sucked

I learned that if you are patient enough to listen to the patient, they will tell you exactly what is wrong, although they will not always tell you in words.

I treated an eighty-year-old French Canadian man who lived with his son's family. He had a very thick French accent and so his son spoke for him. He had two complaints. First, he could not sleep for more than an hour to an hour-and-a-half before he would wake due to neck pain and have to reposition himself. Complaint number two was that, because his back hurt, he was unable to keep up with his family on their daily walks. He had had a cervical fusion of his entire neck just after World War II. This is a surgical procedure wherein the vertebrae of the cervical spine are permanently fixed to each other to provide stability at the expense of movement. Although the bones of his neck were therefore immobile, I planned on addressing the muscular tension that had probably been there ever since. I planned to do the same for his back.

I treated him on four or five occasions. Every time I would ask him how he was doing, he would give me the same answer: "I'm doing shitty, terrible." Each time I treated him, I felt that his tissues were softer, more pliable, with greater range of motion in his low back, and always the same answer: "I'm doing terrible."

By his fifth treatment he was sleeping through the night without waking and he was able to keep up on walks with his family. These were the complaints he gave me when we started. Objectively speaking, his complaints were fixed. I would always ask how he was in order to address whether or not I'm making any progress with his initial complaint. What I didn't realize was that he was answering me from a deeper part of himself. His answer "I'm doing shitty" referred to his feelings about being eighty and in poor health and not having a fulfilling life. It had nothing to do with the question I had asked him.

Although I addressed his complaint, I feel it is more important to address people's deepest concerns and problems. If you are willing to listen, then perhaps your patients will be willing to trust you with their woes and their most cherished desires. One of the

chief tenets of osteopathy is to treat the patient "as a whole." Holistic medicine has become a buzzword today, but this is an old principle. Treating the patient as a whole means looking and listening for key problems, not just what they tell you.

In this particular case, I wasn't able to do much more for this elderly gentleman. I was still a student, and the man's son stopped bringing him in, since his presenting complaints had been resolved. But over the years I have been able to develop more ability to keep going until the deeper problems are identified and addressed. This approach gives me more authority to effect a more complete change. Sometimes this means listening to a patient's story. Sometimes it means holding a patient's hand while they cry. It might mean taking the time to find the appropriate people to refer the patient to. Is this different from visiting a doctor in an HMO who's running between three patients in three examining rooms? Does it change the nature of the doctor-patient relationship? Of course. How far the patient wants to go on these deeper issues is up to the patient. While it is true that you can lead a horse to water but you can't make him drink, you can, however, make him thirsty.

Always in a Hurry

I was a student working at a clinic where a few doctors would see maybe a hundred and twenty-five to a hundred and fifty patients a day. I had done several rotations through this clinic and the doctors knew me well. My boss would ask me how many people I could treat in one hour. I said two or three, so he would give me five or six. After several months at this clinic, they were pretty confident in my ability and I treated everyone from newborns, to pregnant women, to basically anyone who wasn't getting better.

I remember it was a Tuesday when I treated a young man in his early thirties. He had been busted up in an auto accident one or two days before, had gone to the hospital, been medically cleared, and was then sent to us for follow-up for his musculoskeletal pain.

He came complaining of severe low back pain and he was black and blue, as much as was to be expected from his recent trauma. I treated him and told him to follow up with me in two days—he was hurting pretty bad. I saw him on Thursday, wow, he looked great! He felt great! I thought I had done a good job, but this was much better that I had expected.

I told him that I would see him after the weekend. I expected that he should continue feeling good but that he should take it easy and avoid strenuous activity or heavy lifting. I told him that if he needed me he could call me anytime.

Friday morning, twenty-four hours later, he was waiting for me when I came in. He was doubled over in pain. Shit! This doesn't make sense. He was too good to be true yesterday and too bad to be believed today. I examined him. What I felt over his back did not *feel* like back pain. I wasn't sure what it was, but I knew it wasn't his back.

I felt over his lungs. I don't recall which side now, but I remember that one particular side did not feel right. I listened with my stethoscope. I heard nothing abnormal. I asked a physician assistant with a lot of ER experience to listen to his lungs. He heard nothing abnormal. As a medical student I found myself at a loss. I asked Santos, the physician assistant, "What's a lung test we could

do?" He said we could send him for a V/Q scan. I didn't even know what a V/Q scan was, but it sounded like a good idea.

I went back to my boss, who was a good-natured kind of guy, and said, "We need to send him for a V/Q scan." He replied, "Get the fuck out of here." Some background: a V/Q scan is a very expensive test and this particular patient was an HMO patient, ergo, the incentive is to manage him with the least dollar amount spent.

Well, with that heart-warming endorsement, my boss told me to "go back, give him a massage and get on with it." I went back in to do what I was told. He was writhing in pain on the table. I examined him again. I don't know what's wrong, but I still feel it's a lung thing, not a back problem. "Oh hell," I thought, I might as well go back to my boss and beg for help. I reluctantly went to my boss's office. I asked if he would mind listening to this guy's lungs because I thought there was really something wrong, but I wanted his expertise. A little ego stroking would usually go a long way.

He indulged me. But like me, like Santos, my boss heard nothing abnormal in the patient's chest. He pulled me out of the room and told me "turn the lava light on, whip out the oil, talk dirty to him, give him 800 milligrams of Motrin to take every eight hours, and get him the hell out of here already."

For the third time I walked back in the patient's room to do as I was told. By this time he must have felt sure that none of us knew what we were doing. "God damn it!" I yelled in my head. "What the hell am I supposed to do, go with my feelings or with what the stethoscope tells me?? That's it!! I don't care what my boss thinks, I want what feels right to me!"

I barged in my boss's office, disturbing his avid catalogue time. I never saw someone so consumed with shopping. I demanded, "You either send him for a V/Q scan or you can treat the rest of my patients yourself, I'm not doing another goddamn thing! "Whoa!" he said. "Don't get your balls in a bunch, if it's that important to you, we'll do it, okay?"

And so the guy went for the test. I never gave it another thought. Around 10 or 11 p.m. that night my boss's wife phoned me

and asked if her husband had called. I said, "No, called me about what?" She said, "You know that guy you sent for the V/Q scan?" "Yeah, what about him," I replied. "Well, you saved my husband about a million dollars in lawsuits, that guy had a hemothorax with two liters of blood in a collapsed lung. If my husband had sent him home with a prescription for Motrin, he would have died in his sleep."

Your body has about six liters of blood circulating around. Motrin is a non-steroidal anti-inflammatory pain reliever that increases your bleeding time. In other words, Motrin makes it easier to bleed more. This guy had a third of his body's blood leaking into one lung. How did this happen? He had had a mild crack of one of his ribs that did not stand out on x-ray in the hospital. After I treated him on Tuesday, he later told me that he felt so good that he had been doing some painting and was lifting five-gallon cans of paint (he neglected to tell me this at the time he was writhing in pain). This minor cracked rib then fractured and punctured his lung. He had begun to bleed into his lung by the time he saw me on Friday.

His story seemed to be related to his musculoskeletal injuries, but the feel of his tissues told me quite another story. There is a very different, rubbery quality of feel to muscles that are spasming because of some organ problem such as blood leaking into the chest cavity (hemothorax), kidney stones, or gall bladder stones, compared to muscles spasming because of a strained back. I have repeatedly diagnosed gall bladder and kidney stones first by feel, secondarily by following up with the appropriate studies. I've learned to trust my eyes, ears, and what I can feel with my hands.

Pseudomonas

Before long I got my medical degree and became an intern. Internship begins immediately after you graduate med school. As an intern you suddenly have a lot of responsibility, whereas as a student your opinion doesn't really count. Internship lasts one year and rounds out your basic medical education with mostly hospital work and a lot of hours.

While I was on surgery rotation as an intern, I got called with my attending surgeon, Dr. Joseph Benedetto, to do a consult in the emergency room. We were there to evaluate a man in his early nineties who said he had a boil on his chest and that it had been there for a couple of weeks.

When we walked into the emergency room, we could smell the pseudomonas infection from the other end of the room. Pseudomonas is a microbe with a particularly disgusting smell that permeates a room and makes your nostrils curl. The patient was a chipper guy in otherwise great physical health and with a sharp mind. When he took off his shirt he had what looked like a rat hanging off his chest. What it was was a huge fibroadenomatous cyst the size of my fist engulfing his nipple and draining a greenish pus. It took every bit of my martial arts training to resist the urge to puke my guts out.

Dr. Benedetto asked him, "So that's only been there a couple of weeks?" The patient with the rat piercing his nipple replied, "Yeah, been there a couple of weeks." Dr. Benedetto asked him, "Really? Well, let me ask you…who was president when you first noticed it?"

This turned out to be a simple problem to handle surgically and the patient did well, but I learned that time can be distorted for people who suffer. Maybe, in his mind, it had only been a couple of weeks since he had difficulty getting dressed with this monster in the way, or maybe it had only been a couple of weeks since it started to stink, or maybe it had been stinking for a while but his neighbors started to raise hell only in the last couple of weeks. I will never know exactly what he meant by a couple of weeks.

"Have We Learned Anything, Doctor?"

Internship is pretty rough. Most of the stories about young doctors being overworked fall short of reality. Early on in my internship, I learned one of a myriad of valuable lessons. I was on call some time during my first month. "On call" means that from 7 p.m. to 7 a.m. the hospital is yours. If there aren't many problems, you might get a few hours' sleep. If the roof is caving in, you're going to be on your feet and running the whole time. It's important to keep in mind that the intern on call has already worked twelve to fourteen hours before call starts and will have to work the same twelve- to fourteen-hour shift immediately after call. Ergo, down time, sleep, is a blessed bonus.

I was lying on the couch in the call room watching TV when a nurse phoned me from the general medical floor. She wanted to know if it was okay to have a central line ordered for a patient whose IV (intravenous line) was shot. A central line is an IV that is placed under the collarbone by a general surgeon. The nurse told me that the patient did not have any good veins left to use for an IV. I said "sure" and returned to my important TV program.

The difference between an IV in your arm and a central line is that any of the nurses can place an IV, but only a general surgeon can place a central line. It was about 10:30 in the evening when I got a call from the surgeon. It went something like this: "Hello, this is Dr. Benedetto. You need a central line for a patient?" "Yeah, her IV is blown and she doesn't have any good veins," I said. "Well, what is she getting in her IV?" I hesitated. I knew nothing about the patient except what the nurse had told me, and I'm a lousy liar. "I don't know," I replied. "You don't know, DOCTOR ?!" In this case, "doctor" was not a term of respect. "Did you call her family doctor to order this central line?" I knew that there was no point in delaying the inevitable. "Nope." "Does she need it right now? Can't she get an IV in her other arm?" "No, her veins are shot," I said.

And then the final question: "Did you try?" Here it comes. "Nope...." And then Dr. Benedetto was nice enough to recap the evening's events. "So, let me get this straight. You want ME to get up and come put a central line in at midnight, but you don't know whether it can wait till the morning, you don't know what she's

getting in her IV, you didn't call her family doctor to get a consult for this central line, and you didn't even look at the patient! I have a good idea. Why don't YOU get off your ass, examine the patient, try to start an IV, if unable to start an IV determine whether or not she needs a central line now instead of in the morning, if so, call her family doctor and get permission, then call me back, got it!"

"Yes, I got it." I hurried to the floor, tried to start an IV and failed, but also determined that the central line could wait. Eventually I again called Dr. Benedetto. Retrospectively, I know that he thoroughly enjoyed reviewing, again, everything that I had not done. He wanted to teach me something, and he did. When he was through torturing me over every little detail, he said, "Have we learned anything tonight, Doctor?" I said, "Yes, we have. When all else fails, examine the patient."

Dr. Benedetto taught me to do the best assessment I could. He told me "not to guess with my patients even one percent." If I was not 100% sure of what I was doing, it was okay to wake everyone else up to get help. It wasn't okay to wake everyone else up because I was too lazy to look, listen, and feel for myself. Dr. Benedetto is a top-notch surgeon and now a very close friend who was highly instrumental in my development as a physician.

"Savin' Lives, Sanet."

Most surgeons are high-powered kind of guys. A surgeon I'll call "Dr. Jones," a surgeon for whom I learned great respect and to whom I have referred many patients, was no exception. We first met when I was on surgery rotation as an intern. Dr. Jones would put an arm around a patient and say, "Sanet, you know what I did for her?" and I would answer, "I don't know, what?" and this was always followed by the same reply: "Saved her life. Savin' lives, Sanet, not crackin' backs."

About once a month Dr. Jones would catch me walking down the hall and stop me: "Hey, Steve…." He called me by my first name, this meant he wanted something from me. "Hey, Steve, do you think you could get a chance to look at my back today?" to which I always replied, "Sure, Dr. Jones." I would always do the best job I could. As a rule, surgeons have bad backs and bad necks. This is due to having to bend over a patient during surgery and doing fine, sometimes tedious work, for several hours at a crack.

When I was done, Dr. Jones would always tell me, "You're a good man, Sanet. You know I'm just busting on you." My reply: "I know, thanks. Any time, Dr. Jones." Dr. Jones was a great teacher during my internship, and I am a better physician thanks to my relationship with this top surgeon.

Lung Tumors and Bowling

Pulmonologists spend their days treating diseases of the lungs and chest, and during my internship I spent a month on rotation with a pulmonologist. Most of the patients we saw had asthma or else emphysema or lung cancer as a result of smoking.

Lots of cancer. My doc was great, but it's a depressing practice to me. Of the possible cancers, lung cancer is pretty virulent. Seventy percent of people diagnosed with lung cancer don't survive past six months. This is because lung cancer is relatively without symptoms until it's too late.

One particular afternoon we were preparing to tell yet another patient that he had advanced lung cancer. This gentleman was about forty-five years old and had smoked three packs of cigarettes a day for about thirty years. In medical terminology, three packs per day times thirty years is referred to as ninety pack years of smoking. That's a lot of tobacco. Initially he had noticed that he was beginning to get arm pain and he had just begun bowling. This eventually led him to get an x-ray of his shoulder. His x-ray revealed a huge tumor in the apex of his lung on the same side as the arm that was bothering him. The apex of the lung is the top of the lung between your shoulder and your collarbone.

His arm was hurting because the tumor was large enough that it had begun to press on the nerves in his shoulder that also supply the arm. He had been referred to the pulmonologist for further evaluation. My doc had just done further studies that proved that this mass was indeed lung cancer and we were just about to enter the exam room to tell this guy he probably had less than six months left to live.

We went into the room. Reviewed the x-rays and the other studies. Explained the terrible news in detail. The doc asked him, "Do you have any questions? Is there anything you don't understand?" He said, "Yes, doc, are you sure this wasn't caused from bowling?"

Ninety pack years of tobacco consumption and he wanted to know if the tumor was caused from bowling. This man gave me

unbounded respect for the human capacity for fantasy and denial.

Confusion

This story actually comes from later in my practice, but I'll tell it here. I had treated Daniel for several years for seizure disorder and chronic complaints of confusion. Initially we made progress with decreasing the frequency and severity of his seizures. His complaints of confusion would wax and wane but always persist.

For no apparent reason after several years of intermittent treatment, he commented to me that for several weeks he had felt remarkably clearheaded. He recalled not feeling this way in uncounted years. His memory had markedly improved as well.

I could think of nothing to account for this seemingly overnight change in his mental status. Initially, he seemed quite astonished as well. I asked him, "Is anything different or are you doing anything different in the last couple of weeks?" He said, "No, well, yes, there is something different." I asked, "And that is?" He said, "I stopped smoking pot." I asked him, "How long have you been smoking pot?" "About thirty years," he said quite matter-of-factly. "How often do you smoke?" I asked. "I get high five or six times every day." "Every day?" I asked. "Every day," he said. Epiphany! "Hmmm…I think we've found a variable that accounts for your confusion."

Apparently, you can never overstate the obvious.

Circling the Drain

During a rotation in geriatrics, interns would spend a month in an extended-care unit, kind of like a nursing home within the hospital setting. Typically, on any particular service, interns see patients and then write what's known as a SOAP note. "S" is the subjective part of the story, the part that is open to interpretation or contains the patient's report of their complaints. "O" is the objective findings, lab tests, physical exam findings that we could all agree on and are replicable. "A" is the assessment–that is, the diagnosis, what's medically wrong with the patient. And finally "P" is the plan of action, what we're going to do about this patient's diagnosis by way of treatment.

Our doctor was a smart doc who knew a lot of stuff and was good at it. One morning I was in a crowd of other residents and students grouped around an elderly patient. The patient was intubated (he had a tube stuck in his throat so he couldn't talk even if he wanted to), catheterized (he had a tube stuck in his penis to drain urine), on a respirator, demented, and in generally poor health. As fledgling doctors, we would have said that he's "gorked out," in other words, not with it. This man had a plethora of medical problems to boot, as do most geriatric patients who are in the hospital. We examined the patient and pored over his two ton-chart to come up with the right assessment and a thorough plan.

Our doctor asked us in turn what we thought. We each had our detailed diagnosis and well-thought-out plan. We wanted to finally hear what our master, our mentor, thought about this case. What would be the pearls of wisdom that he would bestow upon us? Our doctor looked down at this poor man and said, "Assessment: CTD, Circling the Drain. Plan: PBTB, Pine Box to Bedside."

This seemed hilarious at the time. It was said in front of the patient. We had the decency not to laugh over his bedside. I learned something very frightening. Death and dying can be mundane. There was no background music playing, no tears shed. This man's life was drawing to a close in this dismal place with tubes stuck up every orifice and our thought was "what a waste of time this is."

The practice of medicine and the schooling of medicine seem

to seek dehumanization as a higher goal. If we dehumanize the patient, we can then be more objective and do the right thing. We thought he was demented, but who knows what he really heard or interpreted in his mind? Should his last thoughts of this earth be that his doc plans to bring a pine box to his bedside?

"Denial"

During the emergency room service of my internship, I found myself taking a routine medical history from an older woman who was being admitted to the hospital for an exacerbation of COPD (chronic obstructive pulmonary disease), commonly known as emphysema. Usually we see this as a consequence of smoking.

So I asked her the routine questions as part of her social history. "Do you smoke?" "No," she replied. "Did you ever smoke?" I asked. "Yeah, but I quit." "Great, when did you quit?" I pressed. "Now….I ain't smokin' no more."

Totally amazing. Age the tender age of eighty after a lifetime of tobacco use, when she's asked if she is a smoker, she says "no." In her mind, she does not consider herself a smoker because after her umpteenth admission to the hospital because of emphysema-related breathing problems, she believes that she won't do it anymore. Denial sure ain't just a river in Egypt.

Vaginas and Fireballs

I've heard some real killers in the emergency room. Some twists on medical jargon have left me nearly laughing out loud, and others made me ready to pound my head against the pavement in frustration.

One of the laugh-out-loud twists was this one. I was taking a medical history from a woman who was going to be admitted to the hospital. I asked her, "Do you have any other medical problems?" She said, "Yeah, I got a vagina in my heart." I almost fell over. "I'm sorry, ma'am, what did you say?" She said quite clearly, "I got a vagina in my heart." I didn't want to ask her a third time because I knew I would get the same answer.

Then it hit me. I asked her, "Do you have angina of the heart?" She said "Yeah, I told you, I got a vagina in my heart." Angina is a condition wherein the heart gets deprived of oxygen, and it can lead to a heart attack. Angina, vagina, close enough I suppose.

More commonly I've been told that "he has the chicken pops" for "chicken pox." I've heard on several occasions that "I have fireballs in the Eucharist" for a condition known as "a fibroid uterus."

On a not so humorous note, I was working in the emergency room one evening and came upon a man whose chief complaint was "fell out." This is what he had identified to the registration clerk as his main problem. I asked him, "How can I help you, sir?" He said, "I fell out." I asked him, "Fell out of what?" He repeated, somewhat agitated, "I fell out." I repeated to him, "Fell out? Did you fall off of something?" Now he was downright pissed off and said "I…FELL…OUT!"

A nurse who saw me struggling leaned over and whispered in my ear, "He passed out." I asked him, "Did you pass out?" He said very matter-of-factly, to confirm that I had finally got it: "I fell out."

"I Like You, Sanet"

There were two docs you didn't want to hear from when you were an intern and you were on call. Such a physician was a man I'll just call Dr. John Doe. Dr. Doe was a nephrologist, a kidney specialist. All of the nephrologists were pretty brainy guys and two out of three in this particular group were easier to deal with. We all trembled when we had to call Dr. Doe about one of his patients. No matter what you did to prepare for the phone call, or god forbid, when he actually came to the hospital, odds were pretty good you were going to get yelled at or insulted for something you hadn't done right.

I never got yelled at by Dr. Doe. I always waited for the axe to fall, but it didn't. I saw the axe cut lots of heads off, but luckily not mine. Whenever I had to speak to Dr. Doe about one of his patients, I went to great lengths to get every scrap of information about the patient so that I could have it ready at hand while I was on the phone. I did a physical exam as best I could, gathered together all of the blood tests that were run in the last couple of days, and got any information that the nurses thought would be helpful.

At the end of my internship, while I was working with Dr. Doe, he turned to me and said, "Sanet, I like you. You know why I like you?" I was sure that I didn't know and I said, "I have no idea." Dr. Doe said, "You're no rocket scientist, but you're not lazy." Wow! a compliment, I think? Then he elaborated: "I don't expect you to know what I'm thinking when you call me in the middle of the night about one of my patients, but I do expect you to do the legwork and have the information when I ask for it."

One of the worst things to happen while on the phone with a specialist is to have them ask several questions to which you don't have the answer and then have them tell you, "Put the nurse on the phone!" I don't mean this as a slam against the nurses. The nurses know what the docs will want to know when they call. As interns we were trying to learn what the nurses already knew and then some.

Another valuable lesson. I might not have all of the answers, but I could make an effort to gather together any clues that might help someone else solve the puzzle. It's never about ego, or at least it

shouldn't be about ego. It's about whatever works for the patient.

All Tucked In

When I worked the hospitals at night, I was in the habit of going straight to the ICU and asking the nurses who was going to be in trouble. They had spent the day with these patients and they knew well who was headed for a crash. I would rather deal with it when I came in than at 3 a.m. I saw a gentleman who was hooked up to every substance known to man. He had IV bottles hanging on poles at every corner of his bed. This is not a good sign. His nephrologist was at his bedside tending to things. Great, I thought, I'll get the advice straight from the horse's mouth, the guy in charge. I asked him, "Is there anything I need to know in particular with this guy if he crashes?"

The doc was real nice and took his time going over the patient with me. He went over all the IV fluids he was getting and the various intricacies. He told me that this guy "was all tucked in for the night," in other words, this guy should not be a problem. I couldn't help but notice that he was getting Levophed through one of his IV bottles. Levophed is a pressor, a medicine we use to keep your blood pressure up. We referred to it in the hospital as "Leave'em – dead" because whenever we saw someone on this medicine it was usually the end, not a good sign. He was also on CAVH (continuous arteriovenous hemofiltration), a self-dialyzing mechanism, another sign of impending doom.

Well, the doc left. Ten minutes later: "CODE BLUE ICU STAT!" I ran up there, guess who, yep, same guy, flat-line dead. He was on so many medicines and his case was so complicated. I did what I was trained to do. One of the ER docs came up to my side. I always appreciated their help if they were not too busy. I was working at night because I was a new doc; they were working at night because it was their regular job. They were far more experienced than I was. I said, "John, what do you think?" He pulled off the monitor leads off the guy's chest and said "He's dead."

I was thinking about all of this heroic stuff I would try in order to save his life and I was hoping to get some avuncular advice. What I got was "He's dead." No drum roll, no heroics, nothing. This guy was only being kept alive in the hopes that his sister would arrive from California before he died. There was nothing to do to save him.

I wish someone had shared that information with me ten minutes prior.

Hello, Anne!

Also while doing my rotation on nephrology service, I learned something very basic and very critical to patient assessment. Each morning we would have to visit, evaluate, and write a treatment plan for every patient on whatever particular service we happened to be on that month. I did my usual and was done before 7:30 a.m. and was quite pleased with myself for getting done so quickly.

When my boss arrived, together we went over what I had done. We went to see each patient, and he reviewed my notes and told me what was good and where I needed improvement. This is how the internship learning process works.

We went in to see Anne. Poor Anne, she was a diabetic near the end of her life. In the intensive care unit, she had a breathing tube going down her windpipe, she had lots of different IV drips going, and was, in my estimation, obtunded.

Obtundation could be defined as one step better than being in a coma and almost totally unresponsive. Obtunded patients, however, do respond to extremely painful stimuli such as rubbing the sternum, or breastbone, with your bare knuckles. My boss said to me, "So, she's obtunded? Are you sure?" He knew her well and he was surprised to hear my account of her mental status. "Yep, I'm sure." I had done a half-hearted attempt at rubbing her breastbone with my knuckles. I didn't want to hurt her and she definitely did not respond to verbal stimulation.

My boss leaned down by her ear. He looked at her so gently, and then he said in the loudest borderline yell, "ANNNNE!" Her eyes flew open. My boss turned to me with the dirtiest look on his face and said, "So...she's obtunded, huh?" One more time, I felt like a complete idiot. It becomes very easy to view people hooked up to machines in the ICU as inanimate objects, lab experiments. Really sick people still retain the ability to process information, they hear what you say about them, and they feel pain when you stick them for blood draws three or four times a day. They don't feel well, but they have the ability to sense 100% of the pain physically or emotionally induced by their hospital experience.

The Twist!

Later in my career I had the opportunity to apply this learning experience and pass it on. I was working as a resident on house call at a local hospital, covering problems big and small, when I was called to the TCC (transitional care unit – another area sort of like a "nursing home" within the hospital). The young nurse who had called me was in distress about one of her patients: "She's unresponsive." Problem time. The biggest reason to be unresponsive in the TCC area is because you are DEAD, which means we need to act quickly, CPR, call lots of people to the room, intubate the patient, and more. Time is critical in these situations.

I ran to the patient's bedside. She was lying there, seemingly "gorked out." She didn't look dead. I have never entered a room and been unable to distinguish a person in crisis from the look and feel of a dead person. As had been shown to me during my internship, I leaned down by her ear and yelled "GINA!!!" Whoosh! her eyes flew open and she screamed in my face, "What the hell do you want!"

I apologized for my yelling and told her that I just came to check and see if she was okay. The nurse and I tucked her back into bed and left the room. In the hallway, I turned to the nurse with my usual boyish smile, not being sarcastic as was done to me, and said "So, she's unresponsive?" The young nurse, I think recently out of nursing school, said to me, "That's strange, she didn't respond to me even when I twisted her nipples, that's why I called for you."

Whoa! I just got a mental picture of how this nurse determined that Gina was unresponsive. I thought to myself, "Is this what they're teaching in school?" I said to the nurse, "If you ever find me lying on the floor and I'm unresponsive, just leave me for dead, don't twist my nipples...unless you're going to take me to dinner or talk dirty to me first." She laughed. Everyone who has ever worked with me knows that I have a very dry sense of humor. I always preferred to make a point with humor or the aid of a magic trick whenever possible. It somehow seems amazing to me that we can become so far removed from another human being that we could devise bizarre and cruel methods of determining mental status when there certainly are easier

ways to arrive at the knowledge we need.

Holidays

Holidays should be a time for families to reunite and rejoice. For some families, it's a time to dump grandpa or grandma off at the emergency room. Shamefully, we would get someone's grandparent in the ER. We would say, "Yep, they're stayin', they have positive baggage sign." Positive baggage sign meant that they came in with their bags packed, so either they or their families expect them to stay.

Within five minutes of dropping them off, their families were nowhere to be found. Drop'em off Christmas Eve and pick'em up after Christmas. We were left with no choice but to find some diagnosis to admit them with. The default diagnosis of choice was usually dehydration. Everyone's dehydrated when you're older and your kids don't want you and you're left at our doorstep.

It should be no surprise that these elderly are victims of elder abuse and neglect. They comprise many of the elderly that we see in hospital beds with positive "O" sign. Positive "O" sign is what many in the healthcare field say to describe someone lying in bed, motionless, with the only expression that of the mouth being open in the shape of an "O." If their tongue is hanging out, we refer to this as positive "Q" sign, with a worse prognosis to be sure.

These barbaric quips that have blossomed out of the healthcare vernacular arise from what is seen commonly every day: the ordinariness of death and dying.

Death and Flies

One of the jobs for interns and residents is to pronounce patients dead. This is an official duty and requires a physician's signature on the death certificate. There is a certain protocol that we generally follow. We check for responsiveness, listen for a heartbeat, feel for a pulse, listen for breath sounds, check for dilated pupils. If everything is negative, they're dead.

Once I was called to check on an unresponsive elderly male. I took one look in the door toward his bedside and turned to the nurse and said, "He's dead." The nurse asked, "How can you tell from there?" I said, "The flies going in and out of his mouth gave it away." There were actually no flies going in and out of his mouth. I've been known to be sarcastic on occasion. I performed the rest of the examination. He was dead, all right. There is a definite look and feel of a corpse. It's never taken me more than a glance to determine what further examination will confirm.

On another occasion I was called to evaluate an elderly woman with difficulty breathing. She was at the end of her life and did not want any heroic measures performed, so she was designated as a DNR (do not resuscitate). I went into the room with the nurse. The woman was propped up in bed. There was no movement of her chest for about thirty seconds. Then she took a rapid, deep inhalation and exhalation. She repeated this cycle in another thirty seconds. The nurse said, "You know she's been breathing like this for quite a while now." I said that's because she's "D-E-A-D!" The nurse said, "Are you sure? She's still breathing." I told her that no one sustains life breathing at a rate of two breaths per minute and that this was brainstem activity, that her heart had died probably a while ago. Neither death nor life has been hard to recognize.

Do Not Resuscitate

One very poorly understood area of medicine in the hospital is the order "DNR," which stands for "do not resuscitate." This is usually discussed with the patient or the patient's family in end-stage problems, advanced cancer, and in the case of the elderly who may not wish for life-saving measures to be implemented if their body systems begin to fail.

First we need to look at what it means to "resuscitate" someone. When a person either stops breathing or their heart stops beating, this becomes a "code blue" situation. Everyone in the hospital runs to this patient's room.

Now comes the task of resuscitation: resuscitation of the heart *and* the lungs. Both need to be done. One source of massive frustration for the docs trying to resuscitate patients is when there is an order for a partial DNR or a DNR with restrictions such as "do not intubate." This is like throwing a life preserver to a drowning man and asking him not to grab onto it.

Families or patients who request restricted DNR's don't understand the process. When the heart stops pumping blood, you also stop breathing. When you stop breathing long enough, your heart stops pumping as well. The two events are intimately linked together, so if you want the docs to intervene in the event of a life-threatening event, don't tie their hands behind their backs.

Here's what I'd say if I was talking to a friend and I wanted them to know everything they really should know about this situation, whether they were making a decision for themselves or for a family member. First and foremost the doctor must be guided by the patient's wishes. In the case of a decision for a family member, I would, as necessary, review any available advance directives and ask the person in the decision-making capacity if they know what their family member had wished. Perhaps the topic has already been discussed. Many times a family member has made their wishes known to certain people in the family, but when the time comes, the rest of the family has confusion as to what to do, or even the decision-making party doesn't know exactly what it means to put the wishes

into practice.

People making decisions about whether they do or do not want heroic measures performed need to know what these "heroic measures" are and what the possible outcomes are. Let's suppose in this case a person has been properly designated to make a decision on behalf of Grandpa. Here's what I'd tell someone I was advising. I would tell them that heroic measures chiefly include measures necessary to keep the heart and the lungs functioning. I would tell them that when the heart stops pumping we would need to inject medicines to try and reactivate the heart. We may need to use shock paddles placed on the chest to send a current of up to 360 joules through Grandpa, and that in some cases this is done repeatedly until you can smell burning flesh. At the time when Grandpa's heart had stopped, he would most likely have stopped breathing. Initially, we would place a mask with a balloon attached around Grandpa's mouth so that we could depress the balloon and force air into Grandpa's lungs. Many times, when it becomes apparent that Grandpa has lost the ability to breathe on his own, we would insert a breathing tube directly into Grandpa's trachea. This involves inserting a tube bigger than any straw that you've seen into Grandpa's throat. At this point Grandpa would be unable to talk as this tube is taking up his entire airway. This is being done so that we can hook Grandpa up to a special machine, commonly called a "vent," that would mechanically inflate Grandpa's lungs.

Very often people will say to me, "I don't want Grandpa to suffer." And their idea of suffering is that they do not want to put Grandpa on a breathing machine should he need it, but they do want us to resuscitate his heart if he needs it. It is imperative to explain that in all likelihood, we will not be able to resuscitate his heart without possibly using devices to maintain airway and lung capacity. Many times these breathing machines are necessary for only a short time. So this brings us back to what counts as suffering, and whether heroic measures can reasonably be expected to have a good outcome, or whether they will merely prolong suffering. Obviously, this will vary on a case-by-case basis.

Once a patient's wishes are clearly known, then the next step is to make sure that all of the proper documents have been filled out.

Without the paperwork, Grandpa's last wishes may go ungranted. This is especially important with the patient who is potentially terminal—although, aren't we all.

Rule of the Ego

After a year of interning, I became a resident. In residency you generally have better hours and are treated with more respect. You also get to specialize in the field you're inclined toward, so for a lot of the time I was doing osteopathic manipulative medicine (OMM). But it's also true that I was still working at hospitals, and one time I was doing night call at a local hospital. Night call was a resident's job. An "attending," a full-fledged doctor not in training, would be sleeping at night, not up working to make a few bucks. The way night call works is this: if nothing is going on, the resident's got a room with cable TV and a bed and a phone. In between fixing problems or major emergencies, a resident can sleep, watch TV, or talk to friends on the phone all night long. It's important to note that although you may have the world's greatest doctor in the daytime, most hospitals have residents covering emergencies on the medical floors at night—someone who is a physician but is still in post-graduate training, overworked, and sleep-deprived.

The general medical floor called me about a patient who had just been brought up from the ER, supposedly stable. Her nurse thought that "she just didn't look right" and asked if I would mind checking her out. "Sure," I said. I would always rather check something out early in my shift rather that have to run and do CPR later.

I took one look in the room and sensed that "something ain't right." The woman was in her late seventies, a frail wisp of a lady, with low blood pressure, a pale complexion, and an irregular rapid heart rate that was not being controlled by her medications. The nurse told me that this woman had been admitted to the hospital under suspicion that she might have a slow gastrointestinal bleed due to a tumor in her stomach. Because of her diagnosis, she was admitted under the care of a surgeon, who I'll call Dr. Richard Roe. She was scheduled to have a CT scan the following day. By the ER doctor's account, she was stable. One look told me she wasn't.

To make matters worse, she spoke only Italian. I couldn't get any information from her. "CODE BLUE ICU, CODE BLUE ICU" rang out over the hospital intercom. Code Blue means that someone is dying. As I ran to the ICU, I told the floor nurse to call

Dr. Roe and let him know that I was moving his patient to the cardiac floor where she could be monitored more closely.

I was managing a major problem in the ICU when Dr. Roe, the attending physician, called back. This was no ordinary attending, he was a surgeon, and a big deal (at least in his own mind), and he made sure that everyone else knew it. When he was in a room, there was not room enough for two egos. "Why are you moving my patient?" he said. "Well," I started, "she's got an irregular rapid pulse ranging from 120-140 beats per minute and she's hypotensive" (her blood pressure was dropping), "so I'm moving her to a monitored bed." He asked me, "What does her EKG look like?" "I don't know, I haven't gotten a chance to get it yet," I told him. "How do you know she needs a monitored bed if you don't have her EKG?" he said with a touch of sarcasm.

I cut to the chase. "She looks pretty crappy." "CRAPPY! CRAPPY!" he bellowed at me. "I went to medical school, I did a surgical residency, I don't remember seeing the term CRAPPY in any medical text, what does CRAPPY mean?!?!" My shit-o-meter was full for the evening, I had critical patients I'm trying to manage, a patient I'm trying to move to a safer place, and a condescending surgeon who was more interested in breaking my balls than the care of his patient. I barked back at him, "CRAPPY means that she is going to CODE some time in the next hour!" (CODE means "code blue" or a life-threatening event.)

Still concerned with getting the last word, he said, "How do you know that without the EKG?" I told him that I had seen a hundred people code in this hospital and they all looked like her. He then snapped**, "**I don't think you're doing your job, isn't that what you're getting paid for?!?!" I had had it. "You know, you're right, let me get that EKG right NOW!" Bang! I slammed the phone down while he must have been in mid-blabber. I told the nurse I wanted to move this patient immediately, the EKG could wait until we got her to a critical care bed. If she was in crisis, she needed to be in critical care, not on a general medical floor where she's checked every eight hours to see if she's still breathing.

While preparations were being made to move her to a critical

care bed, I went back to the task of putting out the fire of another crisis in the ICU. In a few minutes I had a brief respite which I used to call my boss, a family doctor who was in charge of us night docs. I called him and said "Bill, I'm having a really shitty night." I told him of this insane argument I just had over moving an obviously critically ill patient to a safer unit. I said, "You gotta get somebody to relieve me, I gotta get the fuck out of this place tonight."

Bill had never heard me really pissed off. I can recall only one time when I have raised my voice in a working situation. I generally loved working in the hospital. He knew that something must be really wrong. He said, "Don't worry, I'm going to come in to relieve you and I'll be in before midnight." "Okay, Bill, but get here, I need to leave." Fine, I got back to work. I figured I could hold out another forty-five minutes to an hour. Then the phone rang again.

It was Bill again, my boss. "Hey Bill, what's up? You're still comin' in to relieve me, right?" He said, "I'm on my way, but listen, Dr. Roe is also on his way in……to see you…...and he's fuming mad that you moved his patient and that you hung the phone up on him." Boom! My skull was about to split. I said, "Bill, he's an asshole, his patient is in serious trouble and would probably be dead if I didn't act quickly and I don't have time to stroke his ego or run his tests when the writing is already on the wall." I quickly ran through the case with my boss and he agreed with my decision, but he told me, "Steve, just promise me you won't lose your cool with this guy, he's a big cheese in this hospital and he carries a lot of influence."

I said, "He's a prick and he's endangering this lady's life because of his goddamn ego. If I get fired, so be it and if he starts with me I swear to you that we'll be rolling down the hallway locked in a death match." My boss pleaded with me: "I'm on my way, you did the right thing, just calm down and don't make a scene!" I said, "Just get here, Bill, get me outta here."

I went back to work. I proceeded to get the EKG and prepared to move this lady from the general medical floor to the ICU. Maybe fifteen to twenty minutes elapsed. I went down the floor and helped the nurses undo all of the cables and drips and stuff so that we could move the bed out of the room. As we were wheeling

her down the hallway in her bed towards the elevator, I saw a doc coming towards me from the other end of the hallway. I knew it instantly, this is Dr. Roe coming in to kick my ass personally. He was dressed in nice clothes that hadn't been slept in. He had the stethoscope neatly draped around his neck. He looked like he had had a lovely dinner and probably got a good night's sleep.

Behind him about twenty paces was my boss flailing his arms in the air as a silent high sign to me that I should not go crazy when this jerk began dressing me up and down. I continued pushing the bed toward the elevator, toward Dr. Roe. He stopped me, put his hands on the rail and stopped the bed in motion. "Where are you going with my patient!" he barked at me. I took the EKG strip and literally put it two inches in front of his eyes and said, "She's having an anterior inferior infarct, A HEART ATTACK!" and did not break my stride as I pushed the bed from his arms and proceeded to the elevator. All he said to me was "Oh."

What is interesting to note was that actually the EKG showed only minimal changes that could be interpreted as a heart attack. The EKG was read as "questionable." But later, an echocardiogram was positive for the exact heart attack I had diagnosed. The echocardiogram is always done after the heart attack, not during, as it is time-intensive, but it is the conclusive test to determine heart damage. I was complimented by the cardiologist for making this snap diagnosis when the EKG was uncertain. Although the EKG was read as "questionable," I knew that Dr. Roe would probably be clueless anyway. I could have held it upside down and said whatever I wanted and he would have had the same comment probably.

If I had made a mistake and put her in the ICU and she did not have a heart attack, what's the big deal? Maybe $1500-$2000 worth of diagnostic tests and other charges? If I left her on the general medical floor, we would have saved the money only to put it towards a nice tombstone. Given the choice, I would always choose to err on the side of caution.

A Simple Choice

One of the hospitals I used to work at was extremely overworked, understaffed, and certainly overbooked with patients. I discovered early on in my adult life that I am prone to make mistakes; I just hope to learn from them. It is an imperfect world.

Once when I was working, one of the nurses asked if I would look at a patient that she was concerned about. I said "sure." The patient was in his mid-fifties and was admitted to the hospital for an orthopedic surgery. These days this is somewhat routine, nothing to raise any eyebrows. He had no other medical history of significance and so he was on a general medical floor. People with significant heart histories, for example, if they were in for an orthopedic surgery, would be admitted to a floor where they would be monitored more closely for heart changes.

But this was a simple case of a knee replacement. The nurse said, "I think he has a bowel problem." I said, "Okay, let's take a look." I walked into the room and took one look at a man with a severely distended abdomen. It looked like he had a football pointing out of his stomach. I listened to his bowels and I heard normal squealing sounds. He was not in pain. He had had a bowel movement earlier in the day. But he had a rigid football for a stomach.

One of the risks with the bowels is that they can perforate. This is a surgical emergency. When you get a hole in your bowels, you now have an open communication between the outside world (which extends through the body from your mouth to your anus) and your normally separated inside world. Your insides are extremely susceptible to lethal infection in such a case.

The nurse said that he had looked like this for a week and that she had complained to both his surgeon and to his family physician, but since he was able to have a bowel movement the docs said he was fine.

The odd thing is that he had normal bowel squealing sounds. When you have a hole in your bowel, everything stops, no bowel movements, and no sounds. A quiet bowel is a sign of danger, and that one he didn't have. But the football in his stomach, which he

said he never had had before, is a big bad sign for sure.

I ordered the appropriate x-ray to confirm what I suspected and at the same time "CODE BLUE" rang out over the intercom. I rushed to the ICU and spent the remaining hours of my shift dealing with heart attacks and such till it was time to leave. I was the night doc in charge of emergencies. I was not the regular daytime doc responsible for the care of patients.

The next time I came to work, I got called by my boss, Bill. He asked me if I had "***seen***" the orthopedic patient or if I had ordered the stat (immediate) x-ray "***without seeing***" him. I said, "Yeah, I saw him and I ordered the test, why?"

My boss said that the test confirmed a perforated bowel but the hospital had not done the stat (immediate) test for some fourteen hours. This patient subsequently lost his entire colon. My boss said, "You didn't write a note on this patient so I figured that you didn't actually ***see*** him." I said, "I saw him, but there was a code blue in the ICU and I did not have time to write the note and I forgot when my shift was over, but yeah, I saw him...."

I was not sure where this conversation was going. I said, "Bill, did I do something wrong?" He said "Well...., no...., you didn't, you saved this guy's life....but...." I said, "But what, Bill?" My boss said to me that this was going to be a huge malpractice case against the hospital and the surgeon and the family doctor that were responsible for this patient, and "if you didn't ***see*** the patient...then it's the nurse's word against the doctor's."

Now I knew where this conversation was going. The hospital wanted to sacrifice a nurse for the sake of two important, and, I might add, incompetent doctors. They wanted to destroy the career of a nurse whose foresight had truly saved this patient's life. A nurse whose repeated pleas had been ignored, at the expense of the patient. The nurse had documented for a week that he had a distended-appearing bowel. She had documented for a week that she mentioned this to both his surgeon and to his family physician. And even though she had documented these facts, there would have been ways to get around that inconvenient documentation.

I told Bill, "I saw the patient, I ordered the test. The nurse saved his life, not me, and this is what I will say if it comes to court." I told him that if the axe had to fall on someone, then they could fire me for telling the truth, I could always find another job.

The long and short of the story was that the patient lost his entire colon and there was subsequently, to my understanding, a large out-of-court settlement. I kept my job and so did the nurse. I was not shocked to be asked to lie and to sacrifice an honest nurse for two bad doctors. I knew full well that dishonest hospital administrators and dishonest people of high education are no different from other dishonest people. I am just glad not to be one of them. Besides, I'm a bad liar.

Crossing the Rubicon

What I remember about the "Rubicon" was that this was the point of no return. In the present context I am also reminded of mythology wherein Charon leads the souls of the dead across the river Styx, which bounded the gates of Hell. Once I was told by another physician that "you crossed the Rubicon."

I was working late at night, covering the hospital as usual and there was a patient in trouble in the ICU. She was a mentally retarded patient who was in for a gynecological surgery and she was now beginning to have severe difficulty breathing.

When I got to her bedside, she was saturating at 80%. When we talk about saturation, we refer to the amount of oxygen in your blood. Most people hover between 95-100% in the hospital. Below 80% is not compatible with life and we need to do something about it. We were bagging her, which means that we had a face mask over her mouth and nose and we were squeezing pure oxygen into her mouth and nose, and still she was desaturating, her oxygen level was dropping.

The next step is intubation. Intubation is where you put a tube into the patient's trachea so that air goes directly where it is supposed to. There was a problem. She was, I will estimate, about 300-plus pounds (over 135 kilos), had a horse-size neck, and was struggling with us because she was confused. I am qualified to intubate someone in an emergency situation, but in a non-emergency situation it would be the anesthesiologist who does this or a nurse anesthetist.

But it was just me and we were losing her. I could not get her intubated after a few minutes and so I decided to give her a paralytic agent, Tracrium. Tracrium would paralyze her temporarily so that I could intubate her without the struggle. I still could not get her intubated; I tried and tried. Unbelievably, an anesthesiologist was in the house and he came and took over.

He took quite a while as well and he came to me afterwards. He told me not to feel bad because she was difficult even for him, and this is his specialty. I felt better. Then her attending doc came to

me and asked me, "Why did you paralyze her?" I told him that I could not get her intubated with her struggling. The danger of course is that once you paralyze them with such an agent, they cannot breathe for themselves and so it is imperative that the intubation be successful. The doc then proceeded to chastise me that "Once you gave her Tracrium, you have crossed the Rubicon." I told him that the Rubicon was crossed when her oxygen level dropped below 80%. That was the end of our conversation.

A Difficult Stick

While working house call at one of the local bastions of healthcare (a hospital), I was called to draw blood from a "difficult stick," someone with poor veins who is hard to get blood from. The doc working my shift previously told me that she had tried unsuccessfully, several times, to draw blood. "Okay," I said, "I'll get it."

I went down to see the patient. She weighed about 350 pounds. Indeed you couldn't find her veins in her arms. This means I would probably have to do a "femoral stick," which meant that I would have to draw blood from a vein in her hip near her groin. Painful but necessary since we needed to have her blood work.

I asked her, "Where did the other doc try to draw your blood? I don't see any marks." "She didn't," was the answer. The doctor had told me that she tried several times....dammit, she just didn't want to do it. When she saw this patient, she knew that she would have to do a "femoral stick" and she figured it would just be easier to wait till shift change, lie to me, and dump it in my lap.

Here's the best part. I peeled back the patient's gown so that I could prepare to draw blood from her groin. There was a lake of urine between her thighs. This wasn't her fault. She was sick and morbidly obese. I cleaned her up and got the blood as simply as I could. I treated her with respect as I would my mother or my wife in the same situation.

I was not angry at the patient for my having to do this work. I wasn't angry at her for being overweight. I wasn't angry at her for having urinated on herself. I wasn't angry at the overworked nurses in an understaffed hospital for not having cleaned her up. I treated this lady better than the other doc would have and that's all right. I can't, however, conceive of how this other doc decided to devote her life to the non-practice of medicine. I felt that she would instead make a better disgruntled postal worker.

Bus Trauma

The last patient that I saw on my last day of my residency was a pleasant sixty-some-year-old lady. I politely asked her, "How can I help you, ma'am?" She said, "I got run over by a bus." I have been known, on occasion, to be somewhat sarcastic. She looked fine to me. She walked in fine and she was smiling. I said, "You don't look like you got run over by a bus."

She said it happened two months ago. I said, "What happened two months ago?" "The bus ran over me." "How, exactly, did a bus run over you?" She said, "It was backing up and pushed me over." I asked, "Were you knocked out?" She said "no," that the bus had pushed her and she fell onto her rear end.

I asked her if she had any pain. She said "no." I asked if she had any pain in any part of her body. She said "no." I asked her if she went to the emergency room when this happened two months ago. She said "no." I asked her if she went to see her family doctor. She said "no." I asked her if she saw anyone medically since this happened. She said "no." Finally, I asked her, "Why are you here?" She said, quite matter-of-factly, "I haven't had a chance to sue yet, my lawyer sent me here." With a big smile on her face.

I excused myself and told her that I would be back in just a moment. I went straight to the attending physician in charge and told her what this lady had just told me. I told my director that I refused to waste my time with this nonsense for someone who was obviously making a phony case. My director told me that we needed to refer her to Orthopedics and that they would handle the case. I said, "What case? She told me that she has no pain, that there is nothing wrong with her!" The attending physician told me that this was what had to happen with the patient.

Nauseating. I told the attending physician that I refused to participate in any care involving this patient and her bogus claim. She said, "No problem, it'll be in Ortho's hands."

I have always done my best on behalf of the patient. I give 110%. But dishonesty, bogus claims, and ulterior motives are too much for me. This is another thing that I like about being in private

practice. I have some flexibility in determining the people I want to work with and I can choose the manner in which I provide care. Unfortunately today, insurance companies, business people, and others looking to profit from misfortune get in the way of the delivery of healthcare. And even more unfortunately, sometimes the people who come for "healthcare" are themselves the profiteers.

The Happy Heart Attack

When I finally finished residency and became what most people would consider a real doctor, I still worked night call in hospitals occasionally. One night I was covering the house as house physician when I was called to see someone on the telemetry unit. Telemetry is the section where they put people who are in the hospital to have their heart monitored or when heart pathology is suspected.

Anyway, I took care of that patient and was ready to leave the floor when one of the nurses asked me to check on another patient in the same unit. I asked what was wrong. She told me nothing in particular, but he'd been in for several days and no one had been really paying attention to his case.

This was not my patient. The house doctor's job is to be there for major emergencies, not for regular patient management. Regardless, I went to check on this seventy-year-old pleasant gentleman. He had been admitted several days ago with chest pain and had a history of myocardial infarction (heart attack). I was really going in because his nurse had "a hunch" that he needed to be looked at. By this point I had learned that hunches, intuitions, funny feelings, and psychic premonitions are worth paying attention to in the hospital.

There are certain symptoms that we usually see with a heart attack. These include: left arm and shoulder pain or numbness, jaw pain, back pain, chest pain of the kind that can be described as an elephant sitting on the chest, shortness of breath, ashen or pale skin tone, indigestion, nausea, vomiting, and profuse sweating (diaphoresis).

He had none of these symptoms. I asked him, "How ya doin'?" and he said, "Just fine." I couldn't find a damn thing wrong with him, but I ordered a stat echocardiogram—in other words, an immediate one. I wasn't in the habit of ordering stat tests for people with no symptoms, but the hair standing up on the back of my neck was reason enough for me.

The echocardiogram said that he was having another massive

heart attack at that very moment. Would it have been below the standard of medical care if I had not ordered the echocardiogram? No, he had no symptoms. It would have been justified if I had waited until there was a "code blue" called overhead and he was in more danger. Lucky for him the nurse had a "hunch," and so did I.

I don't take people's complaints lightly. When people are already sick enough to be in the hospital, I don't order milk of magnesia for people with indigestion. I make sure they're not having a life-threatening event first. I would always prefer to err on the side of safety rather than miss a diagnosis because I was too lazy to do the proper work-up.

Stalling the Angel of Death

I was working in the hospital one evening, barely thirty minutes into my shift when I was called to the ICU. There was a man having a supraventricular tachycardic episode (life-threatening rapid heartbeat). I immediately did an exam and gave him an ampule of Adenocard. Adenocard is a medicine we use to break this cycle. It's scary when you first use it because within seconds of giving the medicine, the patient's heart will flat-line briefly and then hopefully restore with a normal heart rate.

One dose and his heart rate restored. He was exhausted. I quickly reviewed his medical record and phoned his attending cardiologist. His cardiologist told me that his heart was shot: this was an endgame process but that I should do everything I could to keep him alive. These were his family's wishes. He had already had two previous episodes of supraventricular tachycardia (SVT) today.

I went back to my patient. He was in his late seventies. He said that he was feeling "woozy" again. This was about twenty to twenty-five minutes from the first episode in which I was involved. I looked at his monitor; he was in SVT again. I gave him another blast of Adenocard. It brought him back. He asked me to stop, to let him go. I told him that I could not. And that is the truth; legally I could not.

Had he made this decision prior to entering the hospital, such as having papers made out as a DNR (do not resuscitate), I could have carried out his wish. Without these papers, the physician's hands, my hands, were tied. Had I stopped life-saving measures at that moment, at his request, unfortunately today, the result could have been a lawsuit against myself and the hospital.

All through the evening, every fifteen to thirty minutes, he went into SVT, I gave him medicine to slow his heart, he recovered. He begged me to let him die. No one was going to change his prognosis. At best, he would die within a day or two. No one could change this. He begged me, "Please, please let me go…." It tore me up to be in this fix. His family arrived after several hours of this near

dying and reviving. They begged me to do everything I could to save him. In the early morning hours, his family agreed to let him go. I must have revived him fifteen or more times throughout the night.

At last, with his paperwork in order, he died.

No Limits

I was moonlighting for a senior physician early in my career. He was treating a terminally ill guy who I'll call Aanders; he was in his mid-sixties and he was dying. When I came into the picture, he had been bedridden for six months and was expected to live only a few more months. He had been healthy until Hurricane Andrew hit South Florida in August of 1992. After the hurricane, he had fallen from his roof while making repairs. Initially he was bedridden due to his back pain, or so the doctors thought. Further investigation revealed a terminal disease. Aanders had multiple myeloma, a virulent cancer that originates in the blood and manifests with deep muscle pain and bone degeneration.

When Aanders' senior physician asked me to tag along to treat him, I thought, "This ought to be cool." But when I first laid eyes on him, my thought was more like "Shit, he's going to die any second." He made me feel uneasy. He scared me. I liked to deal with patients that had half a fighting chance. Aanders was clearly a guy at death's door. His hair looked like unkempt straw. His face was sunken and pale. He was nothing but skin tightly stretched over bone, and he and his room smelled like death. What the hell was I doing here? What were we doing here? What could we possibly hope to accomplish?

My colleague proceeded to treat Aanders. Multiple myeloma is a disease that eats away bone, often collapsing vertebrae in the spine. Aanders had so much pain that he could not sit up without screaming. You could not attempt to massage his muscles or he would yell and curse in his language, saying something that sounded like "Oh fur yeagler!" He later told me that what he was saying was "Oh damn!"

Before my colleague could even treat Aanders, he gave him 5mg of intravenous Valium to quell his anxiety so that we could begin to touch him. This same dose of IV Valium could be used in the hospital to stop someone having a full-blown seizure. We would then prepare him to sit up by giving him eight to ten intraspinous ligament injections in his spine. He was injected with Novocain on

various particularly tender points. With all these drugs on board, we would be able to sit him up for about thirty seconds before the pain became overwhelming. Thirty seconds of sitting upright, that was about it.

I visited Aanders several times a week with my colleague for a few weeks. Then my colleague told me that he would be going away for a month and asked me if I would treat Aanders in his absence. "Not a chance in hell," I said. No way was I going to be in a room alone with Aanders when I felt that he was going to expire right in front of me. My colleague told me, "If you don't see Aanders, if he feels that no one is taking care of him, he will die, now."

I always seem to wear my heart on my sleeve. Either that or I have "sucker" tattooed on my forehead, I'm not sure which it is. Well, with the thought that I could help Aanders to live just a little bit longer by being there, I decided okay, why not. Well, I justified this in my head: I figured that I would not use any injections. I would just use my hands. What harm could there be in that? My colleague told me that he would leave all of the injectable medicines there for my use. No way! If I was going to treat Aanders, it was going to be done with just my hands.

I made a treatment plan on paper before I got to Aanders' house. This was going to be the most brilliant treatment in the history of osteopathy. I arrived at his house nervous but eager to do something good. I greeted his sister and mother and proceeded to his room. Then it hit me again like a splash of icy water down my pants. He was lying flat, as usual: pasty complexion, gaunt, with sunken caverns for eyes. This guy could drop at any moment. The angel of death had to be somewhere close by, playing tiddlywinks until the soon-to-be-fatal moment. Was I totally nuts? Aanders looked at me and I could tell that he knew I was scared.

Oh well, I came here to do a job and I'm just going to do it. I had a whole plan in my head, and on paper too. I began softly. Gently placing my hands on Aanders, I allowed his tissues to guide my hands. I treated him for what seemed like several hours but in actuality was maybe forty-five minutes. I got him to sit up, pain free, for about two minutes! Two minutes of sitting up like a human being,

without injecting Valium, without injecting Novocain and without him screaming "Oh fur yeagler!" I was so proud of Aanders, and prouder of myself.

I was almost finished. One last touch. I wanted to give Aanders some breathing exercises that he could do himself. I have been a martial artist for over twenty-five years and I have adapted some of the Tai Chi Chuan breathing exercises for patient use. I am a big fan of home exercise, deep breathing in particular, for several reasons. First, it gives patients some physical measure of control over their pain or illness. Second, it provides an emotional control over their pain: "Hey, this is something I can do to make myself better." And lastly, deep breathing is a de-stressing exercise. I tell people to do these exercises first thing out of bed and last thing before they get in between the sheets. Try this next time you're agitated: without being a Tai Chi master, just take ten slow deep breaths, without holding your breath; when you're finished, you will only be half as angry as when you started.

Back to Aanders. I tailored some exercises for him. This would be the finishing touches to my masterpiece. I showed him how to do these. We did these together. Boy, am I going to be a great doctor! Rarely has osteopathy been applied with such finesse!

Then it happened. While I was sitting next to Aanders on his bed, he looked up at me and reached out his hand towards me. I clasped his hand in mine. He squeezed my hand tightly as his entire body went into an uncontrollable spasm. My worst nightmare rapidly unfolded. The only sound he made was a loud continuous "AHHHHHHH!!!" His tongue was sticking out of his mouth and it was a loud yell like you might expect from a cartoon character falling off a cliff. His eyes looked straight at mine without focus. Seconds passed like years. He made no other actions except for crushing my hand and screaming formless sounds: "AHHHHHHHH!!!" His sister came to my side "Steve, what's wrong with Aanders!" I said, "I don't know, call 911." But I was thinking, here it is: $200,000 in loans from medical school, and this is where it ends. His internist was called while emergency rescue was en route. His doctor asked, "What do you think?" and I said, "He's either having a seizure, a stroke, or both, I don't know."

The plot thickens. While we were waiting, Aanders went blind. After what seemed like an eternity, emergency rescue arrived. I was still on the phone with his internist, telling him what I had been doing. He comforted me by saying, "I don't think that you killed him." What a relief that thought would be as I banged my cup up and down the bars of the jail cell that surely awaited me! He said, "It's probably just his time to die, he's better off anyway." Rescue packed Aanders up and took him to the intensive care unit at the nearest hospital. Aanders' sister and mother looked at me, their eyes probing my soul for the answer to what just happened. I felt sick. My professional life had officially ended before it had really begun.

Aanders was in the intensive care unit for ten days when his vision returned. Typically, if sight does not return within forty-eight to seventy-two hours, it's gone for good. Aanders could see! Two weeks later Aanders was discharged to home. Without any other treatment, Aanders could walk! Further studies revealed that he had no trace of multiple myeloma.

One piece of information that I haven't told you yet: Aanders had refused conventional medical chemotherapy and radiation treatments. When he confronted his internist with his cure from a terminal disease, he said, "Who do you know who has ever beaten multiple myeloma without radiation or chemotherapy?" And his internist replied, "You."

Aanders made me think about a lot of things, not least of which were cancer theory and remission. Every day your body produces one or two cancer cells. First let's define cancer cells: a cancer cell is one that does not recognize its neighboring cells. For example, if we were to grow normal tissue in a petri dish, the cells would replicate until they covered the floor of the dish and then stop. The cells would recognize neighboring cells or would recognize when they had bumped up against a foreign object, namely the walls of the petri dish, and the signal to replicate would be turned off. But with cancer cells, the replication continues, and cells outgrow the container or surface area, forming tumors.

So every day your body produces one or two cancer cells, and every day they are picked out and destroyed by the natural killer cells

of your immune system. So why in some people do once normal cells become cancerous? And why do their immune systems fail to recognize these cells gone awry? Another question: what is remission? Remission means that the cancer has stopped its growth. We can use medicines and surgeries to reduce and sometimes remove cancer. But since your body continues to make cancer cells every day, how do people stop having cancer?

I couldn't really say what my treatment had to do with Aanders' healing. In this case as in many, I feel I may have been like a stagehand preparing the theater in which the body may or may not heal itself. But there was no disputing the fact that Aanders had healed remarkably from a very serious disease. Thus I learned early in my career that the body's inherent ability to heal itself is nothing short of amazing.

Post-Nasal Drip and Cancer

This next case occurred much later in my career, but I'll tell the story here since it shows a very different approach to end-of-life issues from the one I discussed earlier. And again, the context is cancer, but with a different outcome.

An elderly gentleman came to my office and told me he had Stage IV tongue cancer and a tumor the size of a small fist in the root of his tongue.

Cancer staging has to do with the size and the spread of the particular cancer. Stage IV is the end; whatever cancer he has has metastasized or spread to his lymph nodes and to distant sites in his body.

I asked him, "How can I help you?"

He told me his docs gave him about two more months to live and that due to the size of the tumor he had a constant post-nasal drip and it was keeping him awake and uncomfortable all night long.

I told him that I would do what I could to release the fascia in his mouth and assess his cranial bones and that maybe he would see some relief, but I couldn't promise due to the size of the tumor. I told him I didn't think what I do would alter the course of his cancer.

He said, "This post-nasal drip is driving me crazy, I just want to sleep."

I saw him a few days later for a follow-up appointment. He came in very pleasant. I asked him "How do you feel?" and he told me "No more post-nasal drip."

He was pleasant, thanked me and sailed out of my office and I never heard from him again. I have no doubt that he died more or less within the time period his docs had given him.

I thought about him for a while. He was at the end of his life, no cure, no turning back and he was seeking some help for a seemingly mild problem -- when he was going to die anyway?

Was this something I would do if I had two months to live?

And then it dawned on me, it was his two months and he wanted to be able to sleep better.

Spider Web

Once I had opened my own private practice, I was able to concentrate more and more on people with multiple problems and major problems that just hadn't responded to other treatments. Helen came to see me complaining of severe head pain that had lasted since she'd had a kidney removed seventeen years earlier. She had been the conventional medical route without success, seen the best, the smartest. She had head pain that would wax and wane but continued to remain a constant feature in her life.

At this point we could ask ourselves, why would removing a kidney cause a headache? Well, first of all, maybe it didn't. Maybe the headache arose following the kidney surgery, but from some other cause. The chances are fairly decent, however, that the two events were connected, so again we could ask, why *would* removing a kidney cause a headache? One perfectly good if unsatisfying answer would be, "Who knows"? We can't get inside the patient at the time the problem starts and find out the exact cause. Sometimes you get interesting clues from autopsies about causes of a problem, but by then it's too late to help the patient. Moving on, though, here are some thoughts that an osteopathic view of the body would bring to mind.

Some osteopaths say we can think of the fascia as being like a spider web surrounding, separating, and connecting the body's structures. If you cut even a small hole in that spider web in order to remove a kidney, the rest of the web is altered and contorts as a direct result. In turn, the muscles attached to that spider web would themselves have abnormal tension placed upon them. Any number of muscles in the back, neck, or base of the skull could then transmit tension upward, resulting in the kind of tension headache most of us have experienced at one time or another, in one degree or another.

I see people with all types of complaints that haven't responded to other therapies, and they all ask me the same question. "Are you going to be able to fix this?" I answer them all the same way: "I'm either going to fix it or significantly reduce it in a couple of visits, or I will make no difference at all." It's an easy statement to make. With three out of four people I see, I'm able to make the complaint go away or reduce it to such an extent that a short course of treatment is

clearly seen to be worthwhile. One out of four people I see, and it doesn't matter if it's an easy or a hard problem, I do everything I know how to do in a couple of treatments and I get nowhere. If I don't see any improvement in four or five treatments, then treating them a hundred times, from me, won't make any difference.

Along these same lines, I don't treat people three and four times a week until the insurance company screams or they go to the poorhouse. I don't call well people at home to tell them to come in for "maintenance" treatment. And it is quite rare that I order x-rays. I think x-rays are fine when indicated but are far overused to diagnose musculoskeletal complaints.

Okay, back to Helen. While she was on the table getting treatment, her headache of seventeen years…...went away. It doesn't always happen this way on the first visit, but it's nice when it does. I used gentle cranial and myofascial technique mixed with some other gentle techniques known as counterstrain and muscle energy technique. I used deep visceral pressure over the area of her removed kidney to drag the renal fascia upwards and to afford it more mobility. I actually did very little to her head and neck, which was her area of complaint.

I have seen Helen periodically for several years and she has had perhaps a handful of headaches that have resolved easily. She is enjoying life.

Attitude Adjustment

Here's what I haven't told you about Helen….Helen was not the nicest person when she came to my office. She'd been to many doctors over the years, was very wealthy, and had no knowledge or respect for osteopathy.

When I asked her, as I do every new patient, "How can I help you?," she told me "I don't think you can, I don't even know what you do, and I'm not even sure you're a real doctor. I'm only here because my son said I should come." She then told me about her son who was attending a very prestigious M.D. medical school and had aspirations to become a surgeon – "a real doctor" in her terms, and she told me so.

Let me ask you, the reader, a question, the same question I ask all my students who've seen patients with me. As I told you previously, Helen's headache of seventeen years evaporated on the table while I was treating her: gone. I ask the osteopathic students this: "If someone suffers pain for ten years and you treat them and it all magically goes away, what is the emotional response from the patient?"

Every student says "they are happy, relieved, ecstatic," et cetera. No, they are in disbelief that anything has changed. They have become the person who is forever suffering, emotionally and physically. So many times I have had patients suffering for many years have their pain go away, only to tell me on follow-up that "nothing has changed, nothing at all."

There are certain expectations we have, and often our brain jumps forward out of the present and we find what we predict or what others, especially physicians, have predicted for us.

If you are fairly healthy and you hurt your back, hurt it so bad that it's painful just to get out of bed, you have an expectation that tomorrow or in a few days things will return to normal. If after a few days you are still in pain, fear begins to set in: "What if this never goes away?" After a year, this is who you are and your expectation is this is who you will always be.

The chronification of pain is total. It is a total transformation of a physical and emotional person into an expected-lifelong-physically-and- emotionally-handicapped person. You transform from "Helen who has a headache" to "Helen the headache person."

Fortunately for Helen, in only a few weeks she was able to re-blossom into the "Helen who has a pain-free life." And the rough personality of an angry disgruntled patient with a headache morphed into a very delightful lady, finally.

Full of Crap

I have gotten and continue to get patients from a huge referral base of other doctors and health care professionals. I'm sort of a "fix-it guy"—no one is quite sure what I'm doing, but I get results with tough cases. I earned this reputation case by case. One such case is Jeanette.

Jeanette's doctor is a very well-known specialist in our area. He had heard of me from an interview I had done on the radio station. He phoned me to tell me that he had a huge practice of head-trauma cases and that he had a lot of patients he might consider referring, if I was as good as I said I was. We talked for a while and then, in a friendly kind of way, he said that he was going to send over some of his toughest cases and see what happened "if you're not full of crap." I thought it was interesting, to say the least, that if I could fix cases that he could not, only then was I a decent doctor.

When she first came to see me, Jeanette had a not inconsiderable history of trauma. At age sixteen she had been involved in a high-speed collision. The vehicle she was in, going over a hundred miles an hour, crashed and burned. She was ejected from the car and walked away; everyone else burned to death. Jeanette came through that accident unscathed, at least physically. She was okay until years later when she slipped on water in a hallway at work and twisted and fell on her back. She herniated four lumbar discs, which were inoperable. Then she had another car accident in which she drove her skull into the I-beam of the van she was in and herniated three cervical discs, also inoperable. She presented to my office with excruciating head pain and back pain, plus sharp shooting pains and abnormal nerve sensations in both legs and arms. She continues to have memory loss, difficulty with speech, and a long laundry list of other cognitive disorders.

Her injury was so extensive that surgery was not recommended to show improvement. She had already been on oral morphine without much reduction of her pain. And, not surprisingly, she was suicidal.

So, here we are. If I'm not "full of crap," then I should be able to cure her. No small task, to be sure. I have always looked at the bigger disasters as a chance to change what everyone else may

have overlooked. The more problems, the greater the chance that I can help something, big or small.

I have treated Jeanette once or twice a week now for several years. My treatment cannot restore a disc that has been smashed and is protruding out of its sac. Jeanette has, however, experienced a significant reduction of her pain, reduction that lasts for several days after the treatment. She says that her pain is much less than when she was on morphine and she doesn't have to deal with the narcotic side effects. She is not suicidal anymore.

I don't want to give the wrong impression here. Jeanette continues to suffer greatly. The perseverance that she and her husband have shown through the worst of adversity would be unthinkable to most of us. But she has shown drastic improvement in her quality of life. We are taking steps in the right direction. I'm glad that in this case I wasn't "full of crap."

Jack and His Harley

Jack fell off his Harley-Davidson motorcycle seven years ago, breaking his neck in the fall. For two years Jack remained in a wheelchair. The day of Jack's accident he had meant to pay his health insurance bill but hadn't got around to it. More than two years after his fall when Jack again had insurance, a neurosurgeon performed an operation to relieve compression of his spinal cord in his neck.

Adding insult to injury, the surgeon told Jack that had this surgery been done at the time of the accident, he might not have lost the ability to walk. No one would operate on him at the time of the accident because he had no insurance.

After this last neurosurgery, Jack was left with scattered muscle strength and sensation. He remained in a wheelchair. When Jack arrived at my office, like everyone else he wanted to know if I could fix his problem. I gave him my usual answer. I also explained that I listen to what you tell me and why you're here, and then when I put my hands on you I completely disregard everything you tell me and I treat what feels restricted to me. I expect to do this three or four times and either make your problem go away or reduce it enough so that a short course of therapy will have been worthwhile.

Aside from Jack's obvious deficits in muscle strength, coordination, and sensation, he had significant complaints of spasm. Spasm is a common problem with people who have spinal cord injuries or who have suffered a stroke. Conventional medical treatments for spasm include both long-acting muscle relaxers and injections into the spasming muscle of botulism toxin (a poison) or phenol (another poison). Muscle relaxers work by blocking muscle action in the central nervous system, and botulism toxin and phenol work by blocking the connections between the nerves and the muscle tissues at the motor end plate. These are two things that I don't wish to do to someone who doesn't have the full use of either their nervous system or their muscles.

When Jack came to see me for the second time, I asked him, "How ya doin,' Jack, better, worse, or the same?" Jack said to me, "Y'know, it's the damnedest thing." He said he noticed right away

that when he woke up, he could reach over to his nightstand for his medicine without any difficulty. He also noted that when he was lying in his bed and the phone rang, he could just reach over and get it, no problem. "I used to hear the phone ring and then reach for it, but my goddamn arm would immediately go into spasm and by the time my goddamn arm would stop, I would've missed the goddamn call."

The third time I saw Jack we noted that his fingers were beginning to unwind. His fingers had been like claws making a permanent grip. We now noticed this grip beginning to loosen. After somewhat more than a year of treatment, Jack was using a walker to get around and was able to stand on his own. Eventually he became able to walk independently with hand crutches, as much as a little under two miles, and he improved in his duration of walking and also his dexterity.

Brass Knuckles

At seventeen, Harry was beaten in the head with brass knuckles. His right frontal sinus was crushed in. He needed two facial surgeries to reconstruct his sinuses. He was left with daily severe head pain. In time, it was recommended that he have nerves over both eyes severed to relieve his pain. That surgery was also performed twice, without improvement.

When I met Harry in his early forties, after a lifetime of pain and disability, he had been taking as much as 1000 milligrams of Demerol and 500 milligrams of Vistaril by multiple injections every day. Demerol is an extremely potent narcotic and Vistaril, though classified as an antihistamine, chiefly acts to potentiate the effects of opiates and therefore can be highly addictive. Either of these medications can be addictive on their own, not to mention in combination.

An average person might have one-tenth of Harry's dose of medicine after a surgical procedure to control pain. My feeling is that Harry ended up on these medicines because of his constant complaint of head pain and frequent trips to his family doctor, specialists, and the emergency room. If you complain enough, unfortunately, somewhere down the line the conventional answer will involve medicating you into oblivion. People in a semi-coma tend not to complain as much as conscious people.

When I first met Harry, no one had to tell me how he was feeling. He looked like he was carrying a thousand pounds on his shoulders, with bags under his eyes from lack of sleep, and a slow shuffle for a gait. The only thing that was missing were the dark glasses.

By the second treatment, he walked in with some bounce in his stride and a smile on his face and he looked like he wasn't having sleepless nights. He was treated with gentle craniosacral technique to stabilize a hypermobile, twice-reconstructed frontal bone. I used gentle frontal bone lifting techniques in conjunction with synchronizing the micro cranial motion along his metopic suture (the suture between the once separate frontal bones) and pterion (the junction of the sphenoid, frontal, parietal, and temporal bones).

Specifically, I spent a lot of time bringing both sides of his frontal bone into phase with the craniosacral rhythmic impulse. In the fetus, the frontal bone develops from two separate ossification centers. Having developed from two originally separate bones, the mature frontal bone retains some elements of rotation as well as flexion and extension as it relates to the inherent motility of the primary respiratory mechanism (commonly known as the craniosacral rhythmic impulse). For the frontal bone to be out of phase is like half the lung breathing in while the other half breathes out. To be more efficient, we need both halves doing the same motion at the same time.

The most difficult aspect of Harry's treatment was to wean him from "junkie" doses of physician-prescribed narcotics. Harry continues to have head pain, but he has had months without it and his pain has been controlled without the use of narcotics (see the discussion of pain at the end of Part II of this book).

Harry doesn't live in the emergency room anymore.

Migraine Suicide

Enter Ken, a twenty-six-year-old husband and the father of a beautiful eight-year-old girl. Ken fell from a loading dock about fifteen feet onto a metal spike that went through his elbow and into his jaw and face. He had had reconstructive surgery to his jaw, which left him with a constant crushing headache and unable to eat anything hard.

His wife was desperate for help. Ken was suicidal for obvious reasons. He had a soft diet plus constant pain such that he couldn't work, and that does not leave much of a reason to want to wake up tomorrow. I told Ken and his wife that I would do all I could to help him, and I meant it, and I have always meant it.

I treated him maybe six or seven times without any change at all. In the world of overtreatment and patient abuse in the quest for dollars, I have always respected people's pocketbooks. After this much treatment without any result, I did not feel that continuing would make any difference. His wife wanted to speak to me privately and she pleaded with me to continue to treat him. She said that she was afraid that he was going to kill himself and that I was the end of the line, medically. I told her that I would be happy to continue to treat him, but that I honestly did not think that anything would change.

I saw him a few more times. Something shifted. Something changed. His head pain stopped. Within another month or so, he was eating hoagies, no head pain, and back to work. For those of you not from Philadelphia, hoagies are great big sandwiches often made on heavy crusty rolls. I am ever astonished at the human capacity to be well. It is unfortunate that much of medicine seeks to predicate the patient's future on the present. It may be true that his headaches might have persisted forever. I also do not lie about rosy outcomes or spend patients' money needlessly, hence the reason I insisted that I would continue as long as his wife understood that I did not have a track record to suggest any other outcome.

Humans do, however, have the capacity for total wellness. I don't always see it, but I believe the possibility exists. If you don't believe in the possibility of wellness, then how can you pursue this

goal?

Trapped

Larry came to me disabled: unable to work due to pain radiating from his right wrist, elbow, and shoulder. Right-handed, forty-eight years old, he had made his living doing construction but had been unable to use his right hand since an injury three years earlier.

Larry had begun having excruciating pain in his right hand after doing a roofing job. He had had positive EMG's **(**electromyographs**)** that demonstrated nerve damage. He was unable to grasp his tools and therefore unable to make a living for his family. His blood pressure had risen also. Almost two years after the beginning of his disability, Larry had had surgery on his hand to try to relieve his pain and restore his function. After his pisiform bone was removed (one of the bones that make up the wrist), his pain and weakness continued. He tried acupuncture. He tried cortisone injections. Nothing helped.

In he came to my office. When I looked at him, I saw a basically healthy man. But when I looked at his wrist, I saw a thick, red, nasty-looking scar left from his surgery. My treatment was to apply specific pressure along his scar with my fingers. I did this in order to release any adhesions of the superficial and deep tissues. My hope was that perhaps there was some nerve entrapment that had gone undetected, that perhaps releasing this would allow some decrease of pain and improve his function.

What I got on the follow-up visit several days later was a miracle. He had no pain. He had full motion. Larry went back to work after having been disabled for three years.

Surgery or Not?

Mike was a professor at a very prestigious college, in his late thirties, and he enjoyed weight lifting. On his first visit to my office, Mike was reeling in pain, bent over and with a severe limp from the pain.

Aside from the condition he came in with, Mike was in great physical shape and with a powerful build. His story was that he was dead-lifting some enormous amount of weight when he both heard and felt a loud "pop" in his low back and dropped the weights.

He first went to his family doctor who set him up for a neurology consult and an MRI, assuming he'd had a herniated disc in his lumbar spine. Certainly his presentation to the family doc, if it was the same way he limped into my office, warranted the studies and the pending neurology appointment.

So I treated him. He had a tremendous spasm of his lower back muscles. I used some myofascial techniques to ease the spasm and I used some visceral (organ) manipulation to override the pain signals that were reinforcing the spasm.

Visceral technique (or organ manipulation) was a very powerful tool in his treatment. Often lumbar pain and spasm is multifaceted. It isn't just one thing but a combination of pathologies that keeps this vicious cycle going.

If you think of your spine as a series of bricks stacked one over another, then your discs are the softer things between the bones (or bricks).

In actuality the disc is a very gelatinous substance that is encapsulated by a very tough sailcloth-like substance called the annulus fibrosus. A herniation is a tear in the annulus, and the gel inside, the nucleus pulposus, oozes out.

It's like toothpaste out of a tube. It isn't going back in. No one is going to "unslip" a slipped disc.

But often the pain occurs because of the spasm of the muscles overworking, and also the edema or swelling to the now

irritated area puts increased pressure over the nerves exiting the spine via the neuroforamina.

Visceral manipulation puts pressure on the nearby organs, such as the large intestine, and that creates nerve signals (proprioceptive signals) that go back to the spine and are louder and stronger than the pain signals. In this way I was able to override some of Mike's pain signals, which were no longer necessary since some of the spasm had been released with myofascial work.

But this was no easy case. When I was done he still looked miserable. Often it takes a few days for the body to adjust to treatment, and he was in such terrible pain that I told him to go home and rest and see me in a few days for a follow-up.

Honestly, I thought he had, as his family doctor suspected, a severe herniated lumbar disc and that surgery would be his only recourse.

Well, he showed up to my office a few days later 100% pain-free and with a big fat smile on his face. I asked him, "How're you feeling?" and he said "Great, no pain at all, doc." This was puzzling because he had shown all the signs of a severe herniation when he came in before.

I did some mild manipulations to him and he seemed remarkably well to me. He said his family doctor scheduled him for the MRI and a neurosurgical consultation and he asked me if he needed to get those studies done and see a surgeon...since he felt fine.

I said, "You know, you looked so bad when you came in, I would keep the MRI appointment and you can always cancel the surgeon appointment later, I mean no one in their right mind is going to operate on a healthy young guy who has no pain, let me see you after the MRI and we'll talk."

Wow! he came back for a third visit with MRI's of his lumbar spine; the radiologist's impression was of "an exploded L5-S1 disc herniation obliterating the left neuroforamina." Translation: you are getting surgery and you should be in agonizing pain.

He asked me, "Should I see the surgeon?" I said, "Yes, as I said, no surgeon in their right mind would touch you. They will not take the chance of having you come out of surgery worse than you went in, especially since you have no muscle weakness or pain."

But I told him to keep the appointment because "I did not restore the disc. It's toothpaste out of the tube. If you further injure yourself, you may need surgery, so at least let someone see what they're dealing with."

We have a saying in medicine, "If your only tool is a hammer, then everything you see looks like a nail." If you go to a surgeon and ask what can they do for you, you can often expect them to look for a surgical solution. I am not suggesting dishonesty on the part of surgeons at all, they're giving you an opinion based on their profession. Sometimes you need surgery and sometimes you don't.

By the Way……

I had treated Norman infrequently for occasional bouts of back and neck pain. Norman is a professional and highly educated man and has a beautiful family. After one particular treatment for either his back or his neck (I don't remember which), at the end of the session he asked me a "by the way" question.

In medical practice, we refer to patients asking us "by the way" questions when we are ready to leave the room. An example of a "by the way" question is someone who makes an appointment for a simple, irrelevant problem like a hangnail and then when you're ready to leave the room, they say, "By the way doc, I'm having a discharge from my penis…." Hence the real reason why they made the appointment.

Okay, back to our story. Norman asked me, "By the way, how are you with sexual problems?" I said with my usual light-hearted candor, "I went to school, I studied, what's the problem?" He told me that he was having trouble in bed, guy trouble. He said that he had these fantasies running through his head that he couldn't stop. They were basically homoerotic fantasies. I asked him if he had discussed these with anyone before. He said that he had told his internist. I said, "Okay, what happened when you told him?" He said that the internist freaked out, obviously became embarrassed, and left the room. I asked, "Did you tell anyone else?" He said that he had told his therapist. "Okay, what happened when you told your therapist?" He said that he had given him various written or verbal exercises to do and that he didn't seem like he really wanted to deal with the problem either.

I said, "Okay, let's find you a new therapist." He said that he didn't feel that would help but that he knew what would help. I said, "Okay, I'm listening." He said, "If you would just jerk me off, I'll be able to get over these fantasies."

WOW! No one ever told me about this in medical school! I never saw this one coming. I looked at him calmly as I said, "Well, that's not an option, nor do I think that this would help you get over your problems." I didn't freak out. I didn't run out of the room. I didn't make any judgments about what he had said. He had a

problem. I asked him what it was. He told me. I can't be judgmental about that.

So many times in life we are asked to "just tell the truth and nothing bad will happen." And so many times the people who are asking us to tell the truth are lying to us about the consequences they intend to pursue. You know the questions: "Did you break the lamp, I just want to know, I'm not going to punish you"; "Were you smoking pot, I promise I won't ground you"; "Did you sleep with her, I promise we can get past this." So many times our trust is broken. It is crucial to maintain the trust I have with my patients.

Back to our story again. I told Norman that I wanted to consult some other physicians I knew to see who they might recommend for therapy. He said that he just wanted to talk to me. We agreed that I would get the referral information and we would talk about it in another session. I talked to some psychiatrists and got recommendations of some experts for sexual problems. At our next session I presented this information to Norman. He said he really didn't want to talk to anyone else, he was sure that I could help him.

Well, you can lead a horse to water but you can't make him go to the psychiatrist. Norman's life was functioning well otherwise and he presented no immediate danger to himself or others, so I couldn't force him to get psychiatric care if he refused. We talked for several other sessions. In these sessions he basically reviewed these fantasies, and I listened. After a few weeks the problem had run its course. He no longer had these fantasies, and his bed-time problem in relating sexually to his wife had vanished. He is very much in love with his wife and they are very happy together.

I think the best thing I did for him was to listen, really listen. I had recommended specialists, as I felt this was my responsibility. But since he refused a specialist, given the options of sending him away or trying to do what I could, I chose to do what I could. Listening is an important skill. It has taken me most of my life to cultivate this. Most of us listen, waiting for the chance to give our opinion, or we listen half-heartedly. I didn't know what else to do, so I listened intently. I've been faced with so many other situations, the sudden deaths of children, the diagnosis of advanced cancer, the

physically abusive husbands, that I've learned, usually, how to really hear what is being said to me.

PTSD

I once treated a guy who complained of constant sweating and extreme anxiety. He was a young man in college and quite pleasant. I treated him several times with gentle cranial technique and his complaints resolved for the most part. During the course of his treatment with me I had asked if there were any precipitating factors relating to his extreme anxiety. He told me that he suffered from PTSD (post-traumatic stress disorder).

PTSD is something we usually hear about in regard to Vietnam veterans not adjusting in society because of events suffered in wartime. I asked him what had happened to him. He said that at a young age he had been abducted for several years and then returned to his home. He said this with a straight face. Shit! I never would have guessed this in a million years. I put him on a low dose of medication to help with his remaining anxiety and put him in touch with an excellent psychologist to work on the deeper levels of healing that he needed. I've learned that not everything can be read in a handshake, a smile, or even knowing a person on a deeper level. Some of the vaults that we hide our emotional traumas in are very secure and can withstand a lot of dynamite.

Some vaults are on a time-lock, waiting for something to precipitate its opening. Such was the case for another patient, Phil. Both Phil and his wife had professional jobs. His wife was supportive, and they had wonderful children. In addition, Phil had two brothers, and in adulthood one of them died. When he died, something died in Phil. Whatever had been holding him together suddenly became unglued. Phil and this brother had been sexually abused by a family member when they were children. No one knew. No one ever knew. Not his even his wife.

Phil began to have horrible nightmares, crushing head pain, back pain, high blood pressure, and fits of rage. His life fell apart. He stopped working. Everything he had ever had was in sudden jeopardy. My part in Phil's healing was and continues to be small. I have used cranial and visceral (organ) manipulation and have been able to resolve his head pain and his back pain and add a degree of calmness to his life. His fits of rage are under control and he does not have high blood pressure any more. He is going through extensive

counseling and making progress. Phil's healing is far from over, but he is on the right path.

Cases like these have led me to the conclusion that whatever we don't deal with emotionally, we somaticize. The extent to which we somaticize is variable. Our bodies are proprioceptive recorders for all of our life experiences. We remember important events that we heard. We can visualize critical experiences that we have witnessed. And our tissues, our fascia, our musculature, and our internal organs can store emotionally painful events. Once an emotional event has become part of our fabric, I have learned, from one of my mentors, "What doesn't work its way out, works its way in." There doesn't appear to be a third direction.

Sweat

I once had a patient whose complaint was "I sweat constantly." She was a lovely young lady who had been embarrassed by this problem. She came to my office because I was known to fix difficult problems. What could I do for her?

Well, let's look at the problem. She sweats inappropriately. Sweating is a function of your involuntary nervous system. Your involuntary nervous system controls things like heart rate, digestion, pupil dilation, blood flow, secretions, and sweating. It moderates these functions between what is known as a "vegetative state" and a "fight or flight" state. A vegetative state is one wherein your body is digesting food and not involved in heavy physical labor. A fight-or-flight state is one wherein digestion is relatively shut down and heavy labor (like running away) may be involved. Our involuntary nervous system prepares our body to meet either of these demands by making adjustments to our heart rate, blood flow, and so on.

With heavy activity or a fight-or-flight state, the body needs to have a mechanism for cooling itself: sweating. So someone who sweats too much has a nervous system that is in the fight-or-flight mode too much. The nerves that carry this fight-or-flight information can be accessed in the mid-back. Manual stimulation of these nerves via mobilization of the posterior rib heads was the technique I used that stopped the excess sweating.

FLK, ADD, ETC.

Did you ever see a kid who you felt must have something wrong because he or she was funny lookin'? There is an old pediatric term for this. These children are known as "FLK's" or "funny lookin' kids." No joke, this was an older, politically incorrect term used to describe a kid whose head "just didn't look quite right."

Unfortunately for these children, oddly shaped heads by and large get diagnosed as normal. If an x-ray and an MRI are performed and no lesion is found, the heads are thought to be normal. The reality is that many of these children have strains in their skulls similar to strains you might have at any other joint. One major difference between a strain in the skull versus elsewhere is that the joints in the skull are less forgiving than many other joints, and the net result may cause increased pressure on various areas of the brain.

Pressure over the temporal areas of the brain can result in seizures. Frontal lobe pressure can result in personality disorders, while occipital lobe pressure can adversely affect vision. I have observed children coming into my office with a range of complaints—attention deficit disorder, attention deficit hyperactivity disorder, global developmental delay, pervasive developmental delay, autism—to have significant restriction in the posterior part of their skulls. This restriction creates the effect of having prominent edges on the back sides of the skull known as the posterior parietal horns.

On the top of the skull, babies have two areas known as fontanels or "soft spots." Of these, the posterior fontanel (near the back of the head) closes first and the anterior fontanel (near the front of the head) usually closes by age two. Often what contributes to the "funny lookin'" head is closure or restriction in various sutures of the skull, sutures being the borders where adjoining bones of the skull meet. If sutures become restricted in the back of the skull, it is likely that the anterior fontanel will remain more prominent and take longer to close. This happens because as the brain grows, it can't grow easily in the restricted area and thus grows more toward the non-restricted area, accentuating the non-compliant or restricted feature of the skull.

Very often these developmental delays or behavioral patterns

may change more or less dramatically when these restrictions are relieved. The younger the child, the more likely they may be to develop a normal-looking skull over time with treatment. In adolescents and adults, treatment is less likely to change what the skull looks like, but the effects of strain can still be changed or eliminated with cessation of the strain.

One such radical behavior change happened with a male patient about fourteen years old. Preston's mother brought him in for treatment, concerned that he had been diagnosed with attention deficit disorder, was doing poorly in school, and was quite oppositional at home.

I said, "Hi, Preston, how ya doin'?" to which he said, "This is all a bunch of bullshit, you're wasting your time." In general, I would say that if this kid acted a little nicer he might be considered a rotten brat. Mom wanted to know what my prognosis was.

I don't think that anyone wakes up and decides to look for an osteopath who specializes in cranial and organ manipulation just for the heck of it. People have sought me out because I have gotten results where others have failed. It's that simple. I told his mother that I would treat him three or four times and that I expected to see a radical change in his behavior, otherwise further treatment with me would be useless. If I'm able to get results, I get them quickly.

I treated this unruly adolescent maybe four times. He began doing his homework, no more disciplinary actions at school, he listened to his parents, and, amazingly, he was nice to me. He had had extreme tightness in the back part of his skull. This was relieved. Even more amazing was this: later within the year, his parents got divorced and it was a very difficult divorce, a perfect chance to relapse. But Preston continued to do fine, a real pleasure to talk to.

Another such case of attention deficit disorder occurred in a boy whose mother brought him in against his will. He was about thirteen years old and in daily detention for disrupting his class. During my examination, he continued to snap the fingers of both hands. It began to get on my last nerve. He just kept snapping and snapping. He couldn't keep any other part of his body still either. He kept moving his arms, moving his legs, fidgeting in his chair. A

serious case of "ants in the pants."

After several treatments, Ricardo's "ants in the pants" left. I can't necessarily say that Ricardo became likable, but his need for constant movement stopped. So also did his daily detention. All this without Ritalin, the drug of choice for attention deficit disorder.

Other kids' heads may not be "funny lookin,"' but they may suffer nonetheless from restrictions within the cranium that result in dysfunction. Again, these may include ADD, ADHD, depression, anxiety, global developmental disorder, autism, and more. Robbie's mother brought him to me at about age ten. Her complaint was that he was very oppositional, wouldn't listen when told to do things and was generally hard to get along with. I treated him with cranial manipulation maybe two times and his mother said that he was a totally changed person. He did what he was told around the house and was pleasant to be around.

Since his initial treatment I have seen Robbie on a few occasions when he took a bump in the head and began demonstrating his old behavior. His mother and I have noticed his behavior change like the flip of a switch both when he takes a minor injury to his head and when the strain is corrected by cranial manipulation.

Penelope's mother asked me if there was anything I could do for her daughter, who was autistic and high functioning. I treated her with cranial manipulation two or three times and we noticed some big changes. Her mom said that previously Penelope understood that a red light meant stop and a green one meant go, but the whole concept of yellow was beyond her. After a few treatments, of her own accord, Penelope said to her mom one day while driving, "Mommy, yellow means slow down." Wow! This was from the same little girl who rarely put two words together, let alone a whole sentence.

Subsequently, her I.Q. tests have shown an increase. This has been verified by others as well and is not a particularly new finding with cranial manipulation. What is the mechanism for this? I'm not exactly sure, but what is obvious is that whatever was neurologically accessible to the autistic child functions better and perhaps calmer. Calmness is something that is frequently observed with cranial

manipulation. A calm child is most likely more able to perform the same test better than one who cannot maintain any focus. I have noted significant reduction of "stimming" behavior as well (repetitive actions that the child is presumed to perform for self-stimulation), and this includes head-banging as well as hand-waving.

One, two, three...

I treated a family with three autistic children, same mother, same father. I cannot even begin to imagine the devastation of having three children, separate births, all afflicted with the same challenging condition.

The two girls were high-functioning, that is to say that they could communicate with words and follow directions, but nevertheless had significant delays in development and were by no means mainstreamed in the educational system.

Roger, the youngest, age seven, was the most severe. He could not communicate with any words that I could understand and he had a propensity for violence. He might come up to you and scratch you or kick you or spit on you. I treated him perhaps eight or ten times over as many weeks. His parents had quite a long drive to get to my office and there was much preparation to maintain three autistic children for such a long car ride.

The mother had told me that Roger could communicate with one-word grunts that she understood. For example, she told me that Roger would bring a can of soda to her and say "soda," but you must imagine saying "soda" fast with clenched teeth and only one syllable. This meant to mom that Roger wanted her to open the can of soda for him.

Well, as I said, I treated Roger along with his siblings over eight to ten weeks. The other children made notable progress, but Roger was not seeming to show improvement. His skull felt so tight to me that I decided that I would need to do some intraoral technique to try to improve what I felt on his skull. I was not looking forward to the idea of sticking my finger in his mouth and being left with only nine fingers at the end of treatment. I need my fingers and I have got used to having ten of them.

But this is what I felt was needed to be done, so I splinted my finger to give me some protection and I had some help from his father and mother to restrain him so that I could do this quickly. We were all covered in sweat at the end of the brief struggle with Roger and I was able to get my work done.

The next week when the family arrived for treatment, I asked mom how everyone was doing. She said, "You know, the strangest thing has happened...." I thought to myself "Oh, no...." She directed Roger to come into the treatment room. She said, "Roger, I want you to count for Dr. Sanet." With the most crisp and clear enunciation, Roger said "One...two...three...." He counted to ten and then said his ABC's clear as day. I almost fell out of my chair.

In the world of communication, first we learn words such as "hungry." Then we learn to make word associations: "me hungry." Then we learn to make a complete sentence: "I am hungry." Roger went in one step from making audible grunts to complete sentences.

My favorite part of the story is when the mother asked me, "Do you think it had anything to do with the treatment?" to which I replied, "Have you done anything else with Roger?" She said no. And I said, "Well, how 'bout we give me a little credit then?"

Honestly, I cannot tell you that I have a protocol for autistic children or that I have a formula for success with these cases. What I can tell you is that I use the principles of classical osteopathy and I treat what feels restricted in the tissues. Every child is different. I have succeeded with many and I have failed as well, but I will look where others may have overlooked.

Since Roger, I have seen children with massive neurological deficit, from a variety of reasons, have a return of function. Regardless of the severity of the problem or the apparent surety of a poor prognosis, I will always try.

Depression

Ryan was a nine-year-old boy who was brought in by his mother because he was suffering from depression. He was being treated with Zoloft, 50 milligrams per day. The scary part was that on presentation he gave a fairly convincing display of anhedonia. Anhedonia is a serious sign. It's when a person doesn't show interest in the things that used to please him or her: a child who doesn't like to play any more, a football coach who no longer wants to watch the Superbowl, or a baker who thinks all food is bland.

Ryan had a significant restriction in his sacrum. The sacrum is the large bone just above your tailbone, at the base of the spine. There was no complaint of pain in this region and no difficult birth history to suggest trauma to the area. Nevertheless, it felt restricted and I did some gentle techniques to loosen the area and then proceeded to evaluate his head for restrictions as well. I treated him two or three times, and his parents told me he had made a miraculous turnaround. His depression had lifted.

He was a happy little boy again. He liked his computer games again and he smiled a lot. They also told me an interesting "by the way, doc." They said, "By the way, doc, he stopped wetting the bed." They had not mentioned this as a problem when they brought him in for treatment, but I'm sure this made a major impact in his nine-year-old life. I haven't seen Ryan since his first round of treatment, and that is a good sign.

Sam and Kermit

At the age of thirty-four, Sam has defied the odds. He was born with spina bifida and his mother had been told he wouldn't live beyond the age of nine. He has had in excess of forty craniotomies (brain surgeries), he suffers with severe seizure disorder, is wheelchair-bound, likes to fish, and is very fond of Kermit the Frog.

His mother, Tina, is a nurse and we used to work together at a local hospital. Tina brought Sam to see me because his back was hurting him more and more.

I treated his back with myofascial technique, specific gentle pressure designed to release tension in fascia and muscles. I couldn't help but notice that his head was misshapen, and so I treated the strain that I felt in his head with cranial technique. Tina also told me that his left leg was chronically swollen and asked if there was anything I could do about that as well, and so I treated his leg with lymphatic technique.

I hadn't been surprised to hear of the back complaints, as they're common among people who can't walk. People who can't walk also get edematous or swollen legs and feet because the normal process to drain the extracellular fluids from those areas occurs from walking and using your muscles.

After a few treatments Sam stopped complaining of back pain and we noticed an immediate decrease in his leg swelling. After a few more treatments we noticed something else: his seizures dramatically reduced in severity and frequency. This was noted at home, in his daycare, and by his neurologist. All in all, his quality of life is significantly improved.

Scott's Frontal Lobe

Scott came from a small town several hours from my office. For some reason I have treated many people from this town and have had a lot of odd referrals to my clinic. Such was Scott.

I had treated his family for a variety of problems. At the time, I would not always know who was scheduled to come to my office or what their complaint was until we met, so Scott was scheduled to come and see me. The morning of his appointment, his mother had sent a FAX to my office detailing his problems. My receptionist brought this to me, but perhaps too late.

Scott was in his late thirties and had a history of four brain concussions resulting in frontal and parietal lobe damage to his brain. The frontal lobe of your brain is responsible for much of your personality and related traits. What was the complaint? Scott's mother stated via the FAX that he has an explosive temper and is prone to destroy furniture among other things...and he hates doctors.

And he's now on his way, alone, to my office. Great, just what I needed. Scott showed up, about two hundred and twenty-five pounds and over six feet tall. I have a background in martial arts, but I prefer the healing aspects rather than self-defense in my daily routine nowadays.

Scott was not destructive in my office and his explosive behavior changed with only minimal treatment. He had considerable compression of his sphenobasilar synchondrosis (a juncture of two important cranial bones which house the brain) and compression of the occipital-atlantal junction (between the back of the head and the first cervical vertebra). These restrictions were relieved with gentle decompression to these junctures.

It is my opinion that his temper tantrums resulted largely from his frustration with his cognitive problems. While he has improved cognition, he still has cognitive deficits resulting from brain tissue damage. But he has a very pleasant demeanor and has rejoined his family for dinners, minus the temper tantrums.

The Body Knows

Sarah is in her sixties and has had numerous complaints of back and neck pain. She has osteoarthritis and is a diabetic. Additionally, she had had a surgery to remove a phalange of her right fifth toe, and was diagnosed with left foot neuropathy of three years' duration, having been told that the neuropathy is a consequence of her diabetes. What all this means is that she had not had movement of the right fifth toe since the surgeon removed one of her toe bones, and she had not been able to feel the inside of her shoes for three years.

Her back and neck pain responded well to gentle manipulation, and this I expected. What I did not expect was that she would regain movement of her fifth toe and that feeling sensation would return to her left foot after three years of numbness. But it happened. How can I explain the results? I suspect that when the bone in her foot was removed, a small motor nerve became entrapped in the fascia healing after surgery. This is what would be most likely to be released from the type of treatment that I performed.

And the numbness? This is a harder one to look at. Diabetes is a disease of the small vessels. One of the complications of diabetes is destruction of these vessels over time. The result is that limbs go numb and in extreme cases rot and die. Eyes go blind as the retina loses this micro blood supply, and simple skin wounds become complicated, since the healing process is difficult without good nutrient supply.

Did I create new blood supply by applying manipulation? This is less likely, but what is likely is that the treatment enhanced already available blood supply and certainly enhanced lymphatic (extracellular) fluid flow. That's what I think, but the reality of what is possible is endless.

In medicine, we try to create theories to explain what we observe, but in the absence of understanding all that we observe, healing occurs nevertheless. I am not seeking to overpower the body with my methods but rather to enhance its existing mechanisms such as blood flow, lymphatic flow, the functioning of internal organs and the like. One of the chief tenets of osteopathy is that the body has all

the necessary mechanisms to heal itself. The fact that in many cases contemporary medicine cannot conceive of this possibility does not prevent the body from healing anyway.

"Oh, By the Way, I Used to Be Blind"

I treated Travis for injuries that he sustained in an auto accident. It was a low-velocity collision, with a result that's getting a lot of medical press today under the term "minimal brain injury." Previously if someone had had a low-velocity collision (say five miles an hour) and the car wasn't mangled and the patient didn't have obvious bumps and bruises, then they were deemed to be "fine"—or "fakers" if they complained.

But what about someone who used to be able to perform calculus-based mathematics in his head before the collision and could no longer do so? Suppose they could still perform well with most cognitive tasks compared to the norm, but they used to be far above the norm? Today there are more significant tests that can determine minimal brain injury, such as P.E.T. scans and others. Certainly, these minimal injuries did exist even before conventional medicine was able to verify them. If we extrapolate from this reality, then injuries can still exist today even in the absence of positive findings on current tests such as P.E.T. scans and the like.

Anyway, Travis had such cognitive impairment. He also had back and neck complaints. All of these problems resolved with osteopathic treatment, the musculoskeletal complaints as well as the cognitive complaint…and something else resolved. Travis had neglected to tell me something else in his medical history. He had had amblyopia as a child, commonly known as "lazy eye." What happens when the vision is not lined up in both eyes is that the dominant eye provides vision and the "lazy eye" shuts down. The brain does this to prevent you from having diplopia, or "double vision." After having been treated by me on and off for over a year, Travis told me, "Oh, by the way, I used to be blind in this eye since I was a kid and now I can see out of it."

"Damn!" I thought. People tell me the most outrageous stuff quite matter-of-factly. What I learned in medical school was that once vision was shut down in an eye, that was a one-way process. Vision was never supposed to come back. What *is* possible with the human mind and body?

Anything.

The Osteopathic Health and Wellness Institute (www.ohwi.org) and The Osteopathic College of Ontario

What started out with healing patients turned into founding the Osteopathic Health and Wellness Institute as a center for treatment and teaching. For years, colleagues and I would kick around the idea of having a local study group, but we always faced the same problem. Where are we going to meet? Each of us had an office that could squeeze in a couple of people and not much more. I tried the local college, which had a laboratory for just this purpose, but scheduling extracurricular time was impossible. So in 1999 I built a place. With the tireless efforts of my assistant, we set about restoring a huge old stone building built in 1906.

Now that we had more space, who else was going to be in the study group? There are lots of people from different disciplines doing bodywork: who should participate? In osteopathic medicine, politics is a major controversy and in my mind a major waste of time. In the U.S., people other than osteopaths do most of the bodywork and treat most of the musculoskeletal complaints. Unfortunately, most D.O.'s are practicing medicine pretty much the way M.D.'s do, and have forgotten the art of manipulation. Given this fact, we opened our study group to all who are doing bodywork and seek to learn and share. We include osteopaths, M.D.'s, chiropractors, physical therapists, massage therapists, medical students and others. Later, in 2000, I replicated a similar model by founding the Osteopathic College of Ontario (OCO).

Today the Osteopathic Health and Wellness Institute and the Osteopathic College of Ontario serve as our teaching labs where we have both periodic study groups and long weekend intensive seminars with a multidisciplinary approach. During my residency, I had done a fair amount of extracurricular teaching for the medical students. I would teach during the evenings and occasionally on the weekends, on my own time and without cost to the students. I have participated in so many seminars that I knew what I liked and I knew what turned me off when I was a student—plus I've always loved to teach since my days as a martial arts instructor.

One thing that definitely turned me off was teaching

institutions that gave watered-down versions of osteopathic concepts. At OHWI and OCO we are about training those who are devoted to healing and are willing to embark upon a path of knowledge as well as training their hands. Today the terms "craniosacral" and "myofascial" have become well known, and quite often a new patient will say to me, "I had craniosacral therapy and it didn't work." My answer to them is always the same. I tell them that I can't make a comparison with the work they received from someone else, as many of the people who claim to be doing similar work have based their knowledge on information taught in huge seminar mills whose dedication lies in packing as many people as possible into a hotel for a weekend and providing them with poor instruction by trainers with little clinical experience. In these situations, participants are taught the craniosacral "cookbook" or the myofascial "cookbook." What I mean by cookbook is that they are taught to do a series of maneuvers that they can use on every patient. Everyone is treated with the same protocol.

I train physicians and bodyworkers to view the body osteopathically and to apply method to the madness. Not everyone with low back pain should be treated with the "low back pain protocol." People are individuals and very often don't fit the standard models. To learn this requires art as well as knowledge.

I have taken a considerable amount of criticism from within my own profession for teaching outside of the profession. To me this is ludicrous. The number of osteopaths who manipulate today is quite small. In this small fishpond, there are those who believe this information should be shared only with other osteopaths, M.D.'s, and dentists. I believe that healing information is a gift to the world and not to a select few. In particular, most of the manipulation performed in the United States is provided by chiropractors, physical therapists, and massage therapists: ergo, I believe it is silly to withhold the information from those who provide most of the treatment.

OHWI and OCO have offered seminars in craniosacral manipulation, myofascial release, lymphatic activation technique, visceral manipulation, and other topics. Beyond individual seminars, OHWI and OCO have also developed a comprehensive program in

osteopathic manipulative theory and practice, which is taught in various countries. You can check current offerings on the web at www.o-c-o.ca; my private practice website is www.ohwi.org.

England

I have a passion for teaching osteopathy. I had taught various topics in osteopathy locally and across the United States, lecturing on all types of manipulative procedures and pathologies. I have introduced osteopathy to M.D. medical colleges in the western part of the United States and have been privileged to lecture at Ivy League medical colleges and academies locally and nationally. I've spoken about osteopathic philosophy and practice, counterstrain theory and application, chronic otitis media treatment with cranial osteopathy, high-velocity low-amplitude technique for the cervical spine, visceral osteopathy and irritable bowel syndrome, diaphragmatic release for acute lumbosacral strain—you name it, there's a good chance I've spoken about it somewhere, in one of scores of presentations.

But I really wanted to make some connections with osteopathy overseas. I was very curious as to how osteopathy was taught outside of the United States. I particularly wanted to connect with colleagues in countries where osteopathy (which had been founded in the United States) was still practiced in the classical way, where osteopathy hadn't basically been absorbed into allopathic (M.D.) medicine.

And because they spoke English, I began with the British School of Osteopathy in London. I got there via the internet. I had tried to find contacts with our European counterparts from my own U.S. osteopathic organization, but without success. So I solicited various osteopathic colleges that I found on the internet and sent letters of introduction. Soon after, I began a dialogue with Mr. Martin Collins, Principal of the British School of Osteopathy (BSO). The upshot was that I was invited to speak.

The BSO was the first school of osteopathy to open outside of the U.S. I was scheduled to speak on visceral (organ) manipulation and osteopathy in the United States today. I had done much preparation for this lecture. In retrospect, it was somewhat odd that I was able to get myself invited to speak at the BSO. I would say that British osteopaths don't always have the highest respect for American osteopaths, precisely because most American osteopaths are no longer really "osteopaths" in the British view, as they've forgotten

manipulation. Likewise, many American osteopaths look down on their European counterparts because they aren't licensed to practice medicine as we do, with prescriptions and surgery.

I flew to Britain with two colleagues who had been instrumental in helping with my educational efforts. The day prior to my lecture all of us were allowed to tour the facility while classes were in session. We sat in on various classes. The atmosphere was one of enthusiasm, quite different from many of the classes I attended in osteopathic medical school in the U.S. During the afternoon, we walked into the back of a class being taught by one of their classical style professors, Mr. Robin Kirk. We were trying to observe quietly in the back of the classroom. The topic Mr. Kirk was about to teach was lymphatic drainage, when, without warning, he noticed us dressed nicely in our suits trying not to disrupt his class.

Mr. Kirk said, "Oh, I see we have some Americans with us today." Apparently, he had not known that I was going to be a guest lecturer that evening and he must have figured that we were just the usual American osteopaths touring their facility with no knowledge of manipulation. He then said, with some gentle sarcasm, "Perhaps the Americans would like to show us what they know about lymphatic drainage?"

I have spoken extemporaneously on many osteopathic topics and I am not a shy person by nature; however, Mr. Kirk's jibe caught me off guard and while I was still contemplating my response, my colleague stepped up to the plate and for the next hour held the class spellbound with his knowledge of lymphatic physiology and technique. About five minutes into this impromptu lecture, Mr. Kirk realized that we were not the Americans he was accustomed to and he applauded the speaker and insisted he continue the entire class.

Well, this was the right way to break the ice. Prior to our arrival, there was some concern as to how much of the class would attend an evening lecture. Word spread like wildfire of our afternoon adventure. My assistant had suggested that we get to the auditorium two hours early so that he would have time to make any last-minute computer fixes. The laptop that I had been using was very obsolete and we had kept it going because we couldn't afford a new one. We

had also brought our own projector to make sure that all of the audiovisual went without a hitch.

So we got there two hours early, hooked everything up, and the computer message said the hard drive was inaccessible. "Damn, I knew it!" In five minutes I had completely sweated through my suit. In thirty minutes the auditorium was packed to capacity. Fortunately, my assistant's expertise allowed us to use someone else's Apple computer laptop to show our IBM PC laptop presentation that he had burned onto a compact disc.

There's nothing quite like going through a total panic two hours before you go on stage, with a capacity crowd. Well, everything went perfectly. I gave a one-hour lecture on visceral (organ) manipulation followed by an hour on osteopathy in the U.S. I told them of the turning away from manipulation by their U.S. counterparts. I told them of the struggle on the part of American D.O.'s to have recognition equal to the M.D.'s. I told them of the HMO's dictating how healthcare would be provided. I told them how osteopathy in the U.S. is struggling to return to its roots. I told them how happy I was to discover that osteopathy, classical osteopathy, still lived and breathed in Britain and that this gave me hope.

The British School of Osteopathy has a pub on its premises where everyone gathers at the end of the day. That evening we made many friends with the professors and students. It is a relationship that has given further meaning to my teaching endeavors outside of the United States and one from which I draw strength to continue teaching.

Belgium

I was invited to speak at the Sutherland College of Osteopathy in Namur, Belgium. The topic was advanced cranial technique. I've found many European audiences to be somewhat dry—that is to say, they've been difficult to read. With an American audience I'm pretty sure, fairly quickly, whether they like me or want to hang me.

Anyway, I was teaching some advanced intraoral techniques. I was discussing one of the more delicate bones in the cranium. I misspoke about one of the properties of this particular bone in relation to its motion in the cranial mechanism. No sooner had I said things backwards when one of the French doctors caught me and let me know.

From that point forward I thought, "Well, my credibility is shot to hell now." I taught the rest of that day fairly uneventfully. The next day I was teaching some particularly uncomfortable techniques under the cheekbone. Often this technique induces a headache or exacerbates jaw pain, even though the final result may be beneficial later. "Can I have a volunteer?" Immediately one of the Belgian doctors raised his hand. He said he had a "click" and pain in his temporomandibular joint, commonly known as the TMJ.

I performed the technique on him. Via the translator he told me that "It's gone. The click and pain is gone!" Okay, I think I earned back some of the credibility I lost. Next I wanted to demonstrate how I do my whole-body diagnosis. This is strange to watch against the backdrop of conventional medical diagnoses. I don't ask for a medical history. I don't ask the patient what's bothering them. I don't ask anything. In about thirty or forty seconds I perform a gentle process of palpation from head to toe that lets me zero in on one or two areas I would define as a "key lesion."

"The key lesion" is an old osteopathic concept stating that there are principal problems from which all the other problems stem. Treat the "key lesion" and the other lesions, often the chief complaint from the patient, will resolve. "Can I have a volunteer?" The French doctor who had caught my mistake the day before raised her hand. Oh, great. It's important to understand that my findings of

the key lesion don't always match the patient's complaint. Nevertheless, when the key lesions are treated, there is the highest probability of resolving the complaint. But the audience always expects a psychic.

Okay, I had her on the table. Thirty seconds later I told her that I found her key lesion to be in her right shoulder. "Bingo!" I saw the look of amazement spread across her face. I just made about a zillion friends in this class. My point remains the same, however: I look for restriction in the body and treat it wherever it may be. To focus on treating the place where the patient feels the pain often takes both the physician and the patient in circles.

Germany

Off to the island of Fraueninsel on Lake Chiemsee in Bavaria as part of a conference conducted by the German Osteopathic College (DOK). The invitation had come through the good offices of Mr. Stephen Sandler, a professor at the BSO and a classical osteopath of rare quality. For my part, I was to demonstrate my global or whole-body diagnosis and discuss osteopathy in America.

As in Belgium, I discussed the idea of the "key lesion." I asked for a volunteer. A young man promptly stood up and approached the table. A half a minute later I told him that his number one problem area was his left inguinal area (groin), number two was his left clavicle (collarbone), and a distant third was that his right leg rotated poorly in his hip. I then dismissed him without giving him the opportunity to agree or disagree with me. I did this because I did not want the audience, via translation into German and French, to lose sight of the "key lesion" concept. Central to that concept is the fact that is that I don't look to the patient for agreement about what I felt in their bodies.

Anyway, the following day after lunch the young man who I had demonstrated on stopped me coming out of the cafeteria. He spoke good English and said, "Doctor Sanet, can I ask you something?" I said, "Of course." I figured, here it comes, obviously what I found on him probably doesn't match what bothers him. He said, "I heard what you said, and I felt what you did, but I don't understand how you did it." I said, "What didn't you understand?" He said that he had had a serious skiing accident and injured his left inguinal area, fractured his left clavicle, and had extreme difficulty externally rotating his right leg.

I again reviewed for him the idea of the "key lesion." It is the outstanding feature of how I approach the patient in every case. The more difficult or frustrating the case, the greater the reason to find a lesion based on palpation and not on diagnostic studies or subjective complaints alone.

Korea

Here I was on a plane to Seoul, on my way to teach osteopathy at Shingu College for the Korean Academy of Orthopedic Manual Therapy (KAOMT). The KAOMT represents highly educated physical therapists who provide manipulative therapy in Korea. As elsewhere, I would be teaching to an audience via a translator, on a topic that was new to them. My course began and everything was going great. On the first day everything was smooth. They were fast learners. Day two we had a wonderful morning and I said to myself, this is going to be a great conference.

After lunch I continued to teach some cranial techniques involving gentle pressure on the back of the head. One of my colleagues who was assisting me asked me to look at one of the participants who was having some neck complaints. I had been demonstrating on pretty much everyone in turn, as is my style of teaching, but I took a look at her and I knew there was more to her story, so I was trying to avoid getting sidetracked with her.

Often during courses participants want to be treated and there just isn't time for this during demonstration. It also causes a problem because then everyone wants to be treated, which is not part of the course. But at my colleague's insistence, I reluctantly sauntered over to her and put my hands, gently, behind her head and began to draw ounces of traction (maybe 50 grams) lightly back towards myself.

Her head began to bend forward and backward by itself. Then her head motion became more extreme and jerky. Her eyes rolled back in her head. Then her left hand began to go through rhythmic movements. She said she couldn't move. Why me, I thought to myself as my previous delusions of grandeur faded. Ten thousand miles from home in a foreign land with people who don't speak my language, and now I was in deep shit.

To ease the pressure, I now had sixty people, my class, crowded around me waiting to see what was going to happen. The woman said she was having difficulty breathing. My host asked if we should take her to the hospital. Decision time. I had been through stuff like this before. She was able to speak. I have never seen anyone

having a seizure and still be able to speak. She could feel my touch in all her extremities. I was pretty sure there was nothing neurological going on.

With regard to her difficulty breathing, she had no medical history, her pulse was strong and steady, and she was young, so I doubted that there was anything wrong with her heart or lungs. But she was definitely having extreme involuntary spastic movements in her head and arm. I asked through the translator if there was anything significant that has happened to her recently. She said no.

After about an hour and a half of following the unwinding of the fascia in her neck and upper back, the rhythmic movements slowed and then ceased. She got up off the table with a smile. She said she felt fine and that her chronic neck pain was gone. I asked again, could she recall anything that had changed in her life recently? She said that she had had a spontaneous abortion three months ago. She had left this out when she was asked earlier.

What was interesting was that two days later she asked, jokingly, via the translator, if I knew any techniques that could make her become pregnant with a boy. I replied, without thinking, that if I could do that I would be the most famous man in all of Korea. In Korea, it is illegal for the obstetrician to tell the parents the sex of the baby during the pregnancy. This is because male babies are highly prized within Korean culture and the knowledge of a female fetus might possibly result in an elective abortion.

With other women patients suffering neck pain, I have seen similar contractions of the cervical musculature that are reminiscent of the same type of cervical extension that the baby undergoes when passing through the vagina. I believe that this unfinished pattern, due to abortion, whether elective or spontaneous—this incomplete birth process—becomes stuck in the mother's fascia.

Whether the woman in my class actually had a spontaneous abortion or an elective abortion is irrelevant. It is not mandatory to learn people's history from their mouths or their minds accurately. Their fascia has a valid accounting of the significant events of their lives. Sometimes the storytelling in the fascia is historically accurate, sometimes it is what the patient strongly imagines to be accurate, and

sometimes it's allegorical. Whichever it is doesn't matter; that the imprinted trauma can be released is what does matter.

What is interesting to note is that currently, at the time I was teaching this seminar, physical therapists in Korea were not reimbursed for manipulation, but they provided this modality because it helped their patients. They do manipulation as a labor of love. For this reason, and others, I have formed a strong bond with my Korean colleagues and I am committed to bringing this healing art to the people of Korea.

Hong Kong & China

I also feel a spiritual affinity when I teach in Hong Kong and China. I have always been drawn to oriental culture, perhaps from my background in martial arts, perhaps not. When I teach in these places, it feels to me that I have returned home after a long and winding road.

I have found Asian customs quite suitable to myself. I have seen some analogous thinking between osteopathy and Chinese medicine. After three years here, osteopathy has grown, and many patients, adults and children, are now reaping the benefits. This is due to the tremendous support from my friends, now more like family, who have made these advances possible through their undying passion to seek knowledge in healing. I believe that osteopathy will flourish in this environment.

Mideast Game-Changer

In spring of 2009 I received an email from a gentleman in Saudi Arabia who asked if I could treat his brother. His brother was hospitalized after breaking his neck in a high-velocity car accident. He was on a ventilator and paralyzed from the neck down.

I do receive so much email about individual patients and at the time, being based in the United States, I was not easily able to travel just to do treatment. Now too most of my traveling is for teaching and usually some treatment, whatever country I'm in.

I knew nothing of Saudi Arabia except as a stereotype of a country overflowing with money. So after a few emails were exchanged, I had made an offer to come for a week at a fair price for my time. Well, not everyone in Saudi Arabia is rich, and both this gentleman and myself were trying to get the Saudi government to sponsor my trip and time just kept dragging on. The visa process was another great obstacle.

Several months went by without any progress on the sponsorship end, the emails were more and more desperate, and I said to myself, "The heck with it, send me a plane ticket and I'll come for free for a few weeks and I'll do what I can for your brother." When I decided to do this as charity, a thousand doors opened up. The visa, which is very difficult to get if the goal is to do paid work in the hospital, suddenly became easy. I had help from my Muslim patients near my office and invaluable help from the Saudi embassy in Washington D.C.

The way my treatment generally works is that I see a patient one day and then again a few days later, having given time for the body to adjust to the treatment. As stated elsewhere in this memoir, osteopathy is based on the body's ability to heal itself. The goal with treatment is to do what is needed for the body to continue with its own healing.

Given that I'd be spending a few weeks to treat this one person, I told my host, "I want to be busy. I will treat your brother every day, but my treatment only takes me thirty or forty minutes, so I'm coming there to see as many people as I can with the time I

have."

Well, I sure was busy and I learned a lot. I spent from about eight a.m. to five p.m. going among three different hospitals and treating dozens of patients with spinal cord injury and brain injuries. In the United States I don't have that opportunity, nor would hospitals allow me to see their ICU patients and treat them with manipulation while in hospital. Strange that hospitals would allow medicine and surgery, which have far more side-effects and unintended sequelae than hands-on manipulation. Nevertheless in Saudi Arabia I was doing just that. I was climbing into bed with patients hooked up to ventilators to breathe for them and IV bags hanging all over the bed.

These were tragic cases, every one of them. I became acutely aware as most of the patients were between twenty and thirty years old and near dead or quadriplegic as a result of high-velocity car accidents. Just days after their injuries, I was treating completely paralyzed young men, the age of my own sons, looking at me, not realizing their more than likely new life of total permanent incapacitation. I worked until my host told me we had to go to the next hospital.

When I was in one room treating a patient there were people coming into the room and grabbing me in the hallway with tears in their eyes begging me, "Can you see my father?" "Can you treat my uncle?" I could never say no to any of them. I didn't leave until my host dragged me away because there was another hospital waiting.

I did this every day till about after 5 p.m., then we had dinner, then we went out to the villages, which meant we went from home to home. I did this until just about midnight every night during my entire stay. I barely got any sleep and yet I was fully awake and fully alive. In each home I would treat one patient, others would get on their mobile phones, and within thirty minutes others would start to arrive. I had to leave each home with the same scenario of people with tears in their eyes begging me to see "just one more, please...just one more."

I don't honestly know if I made any difference to those hospital patients who were quadriplegic or dependent on machines

for their survival. I know I made a difference with many in the villages that were more ambulatory or less severe.

I learned many things during this experience. The most crucial was family. In every hospital the ICU was very modern, much like the United States. They had all the proper machines, medicines, and therapies. One huge difference: in every room I went to, the patients were also being tended by family members. These were patients who had been nearly lifeless for up to one year in these facilities where I was working.

One year in the hospital and still family was doting on them. A young boy would gently take a moist cloth to wipe his uncle's head without being asked. In many cases the patients were not able to ask. A wife, sister, aunt brings tea from home to care for their loved one. It cut me right to the bone, this kind of love, this kind of devotion.

It is difficult to make this kind of comparison with our Western life of iPads, laptops, and big screen TV's. I don't believe that we love our families any less in the West but maybe it is more accurate to say we love them differently. The experience was very visceral for me.

What I have learned around the world is that most everyone, aside from the media's view and perpetual stereotypes, has the same desires, to work to provide for their family, express love to loved ones, try to have a better life through endless difficult times.

I fell in love with Saudi Arabia and my experiences there. More recently I am teaching in many countries in the Mideast, some wealthy, some desperately poor. I am drawn to the poor. I have always had some personal difficulties with charities. I believe they have a good function but by their very nature much of what I perceive I could give them would be disbursed in administration, which is necessary but not where I want my contribution to go -- if not also corruption.

If I donate my time or my treatment to an individual, I know where 100% of my donation went, and I will continue to spend time where I believe it is most needed until I die.

Communication, Conscious and Non-Conscious

I've had a lot to say in this book about communication, on several different levels. There are language barriers and cultural barriers in communicating, and even within the same language particular phrases and expressions can mean different things in different places. There's getting to understand what a patient really means when he says "I'm doing shitty." There's listening and feeling for the emotional problem underlying the physical pain when manipulation alone doesn't fix the pain. There's being ready to hear the "by the way" questions as the patient is going out the door.

All these aspects of communication operate in any genuine doctor-patient relationship, plus one I haven't talked about yet, the issue of conscious versus non-conscious communication. Maybe in osteopathy we have a little different awareness of this issue, because we know that important parts of our communication are body-to-body.

Let's say that each of us exists and communicates on several different levels. For the sake of simplicity, let's reduce this to two levels, conscious and non-conscious. Conscious would be all of the things that you are aware of, non-conscious would be everything you are not aware of.

There are many ways in which we relate information to each other and process information for our own use. When someone asks me how I feel and I say "fine," this is an example of me communicating to that other person from my consciousness to his or her consciousness. "How are you?" Reply: "I'm fine." Interpretation: "he's fine."

Now, let's say that you ask someone "How are you?" and he replies "I'm fine." But something inside you tells you that he is indeed not fine. This is an example of communication between your consciousness and his non-consciousness. Consciously, he tells you that he is fine, but non-consciously something inside him communicates to you that he is not fine.

Let's look at yet another possibility for communication. Did you ever go to a party and meet someone for the first time and think to yourself "Yeah, we could be great friends," and this turns out to be

true? Or the reverse, you meet someone, and before you know anything about them, you think to yourself "Gee, I can't stand this person," and although all of the outward signs may seem favorable and you try your best, you still don't like them? In this case, something from their non-consciousness communicates the incompatibility to your non-consciousness. All of the outward conscious signals may say "friend," but the non-conscious signals all say "warning."

Having recognized that there are conscious and non-conscious forms of communication that we use daily, I would propose to you that the greatest therapy a health care professional can provide will occur by allowing the non-conscious elements of yourself rise to your consciousness and increase your overall awareness. This is the level on which children function and the level that we spend our adult life unlearning.

A further example, from my house: when my oldest son was little and he put a peanut butter and jelly sandwich in the VCR, I called him over to me. I had a big smile on my face and told him that I was not mad and said, "Come here, Nathan." He wasn't buying it. He didn't come any closer. Outwardly I said I wasn't mad. Inwardly, he knew I was fuming at what he had done. Children don't challenge information that comes into them non-consciously, they accept it. As adults we have learned to disregard what we feel in our "gut."

To increase your sensitivity, learn what the child has mastered.

Here and Now

In our house we had a ferret named Angel. Ferrets, for those of you unfamiliar with these creatures, are kind of like a small skinny cat but playful like a dog. One day as the refrigerator door was opened, a dish fell out and chopped off one of his toes.

For two weeks Angel hobbled around with a little ferret cast, but at no time did he seem the least bit discouraged. Nothing of this event seemed to bother him. I thought about the fact that he lives in the here and now. I was sure he wasn't thinking to himself, "Gee, I wonder how I could have avoided losing my toe" or "What kind of future am I going to have without my toe...now I'll never get into the Ferret Olympics!"

I realized that he is strictly in the moment; he does not dwell on the past nor lament his future. He is totally perceptive of his experiences as they are occurring.

It also occurred to me that as a "here and now" kind of guy, he doesn't harbor emotions or dwell on past experiences the way we do. Yes, painful things that happened to him in the past, if they are repeated enough, help formulate his current actions for self-preservation. But he doesn't harbor hatred or love in the way that we do. He wasn't, and isn't, angry over losing his toe. He doesn't hate anybody because a dish fell from the refrigerator.

This same ability to be totally present is what we need to be an osteopath and to find what others have missed. To evaluate a patient with a purely present, filterless touch, to be able to use our hands as a sensation-only organ, this is what the osteopath needs.

Modern medicine is largely dictated by the part of our brain that gathers, assembles, and interprets information. This is not a bad thing, it's a good thing; however, it also blinds the physician to things that are not readily seen, superficially palpated, or found in blood tests and other objective exams.

Sophisticated osteopathic palpation, in my experience, is its own kind of objective approach to the patient. It finds what is truly

there, not a figment of imagination. But to have this deeper sense of human tissue and dysfunction requires a deeper sense of listening, listening without filtration, without editing. When you begin to filter and interpret, you are no longer taking in new information. You cannot both think and palpate, deeply, at the same time.

Momma, I'm Hungry

As I've said, half the patients I see are the kind of patients you might normally think of when you think of a doctor who works with his hands. I see back pain, neck pain and headache, which are half of my day.

The other half of my day are things that you would not associate with manipulation -- recalcitrant neurologic maladies, genetic disorders and anything else no one could figure out.

So a mother brought in her three-and-a-half-year old daughter for treatment. Her daughter had been a normal baby and developed without incident until about age two to two-and-a-half. Then mom and dad found their daughter drowned in their swimming pool. She was resuscitated after being "down" for an estimated forty-five minutes.

To be "down" is how we refer to being recently dead, no pulse, no breath. When the ambulance rushes an emergency patient in without a pulse or breath and they're doing chest compressions and forcing air into their lungs with a bag, the docs will ask the ambulance people, "how long have they been down?"

The longer you're "down" the less likely you'll be revived, and the more likely you will have brain damage if you are revived since the brain soon dies when deprived of oxygen.

This little girl had survived, but only barely. When she was brought in, it was now about a year later, and mom and dad are here because they've been everywhere. What did I offer? I told them I don't know what to expect with treatment, but I would be happy to evaluate and treat her a few times and see what might happen.

I treated her maybe six or eight times and we saw nothing. She remained a lump of flesh with no reactions to any stimuli, essentially dead but with a pulse and able to breathe on her own.

I was treating her for cranial restrictions and I felt that there was restriction in her cranium that I could get at by using pressure from my finger to the roof of her mouth. I do a lot of mouth work, and with kids I usually take a tongue depressor, that wooden stick the

doctor puts in your mouth when he asks you to say "ahhhh," and I break it in half and tape it to my finger.

Most kids bite me and I've been bitten pretty hard, so this is my precaution. But with this near lifeless three-and-a-half-year-old little girl I figured there was no need.

I felt something release and there was a loud "click" sound in her head. And CHOMP! Her jaw closed down on my finger like a vice. There was no chewing, just a sustained incredible force that clamped on my finger and was going to bite it off.

I retrieved my finger with some effort of both hands and concluded our treatment for that day.

On the following week I asked what I always ask, "How's she doing, better, worse or the same?"

I was astonished when the mother told me that her daughter had said the words "momma" and "hungry" through the week. I was actually more amazed that she hadn't thought to call me and tell me this before the visit.

These were the words she was babbling at the time of her development at the time of her drowning and they were the first cognitive things to return.

I don't have a belief that I grew new brain cells for her, but I do have an observation that not everything is as it seems and obviously, in her case, she still retained the ability for speech although it lay dormant until the right stimulus was given.

As an osteopath here is one of the greatest challenges regarding such a child, to be able to sense the dysfunction without being clouded by other doctors' opinions, prognoses, or your personal feelings of sorrow or attachment.

On a personal level, I noticed that of the parents, the father seemed detached and the mother seemed guilty. She could not stop shaking her leg any time I looked at her. I couldn't help but think to myself, "Who the hell was watching the baby?" "How did the baby get into the pool?" "Who's to blame?"

But you can't think about that if you want to palpate something deeper, something hidden. I can't afford these thoughts occupying my mind. I can't think about the zero prognosis that every other doc has given her. I clear my mind and allow myself to feel big and small restrictions wherever they are. I do not want to be the doctor who only has a hammer and sees every problem as a nail.

Edwards Syndrome

Earlier I mentioned genetic maladies, and here is a case of Edwards syndrome, also known as Trisomy 18. It is a rare genetic disorder caused by the presence of part or all of an extra 18th chromosome. It occurs in about 1 in 6000 live births. Of the babies who have it, 80% die before birth and only about 8% live to see their first year due to severe organ malformations and sequelae.

So mom asks me, "Do you have any experience with Edwards syndrome babies?"

It occurs in 1 and 6000 live births…..how could I have experience ? I told her "no," but I was willing to give her daughter a few treatments and see if it made any difference. So I treated this seven-month-old girl till about the age of two-and-a-half, at which point the parents moved across country.

Her previous doctor's prediction had been that this child would never develop any motor skills and would never have sight, and he prepared them emotionally for the death of their child.

At two-and-a-half years she was able to sit up unattended and she wore glasses to correct her vision.

Would I have predicted this result, no; would I have said it was impossible, no. I empty my mind and approach each case from the beginning, where everything is possible. I've seen too many miracles to believe otherwise.

Realities and Theories

How can I explain all of the results I've seen with manipulation? I like the way an osteopathic colleague has addressed this issue. At best, he said, we can attempt to use various models to explain the physical phenomena that we observe. But what if our models turned out to be false? How would that change our observation or our palpatory experience or the results achieved by patients? Not at all. We would, at that point, begin to construct a new model to try to explain our experience.

At one time, many people believed the earth was flat. Despite this known fact, people were able to sail around the world. How did they explain sailing around a flat world? They said that what was actually happening was that people were sailing around the corners of the flat world, and not around or across it.

The point is this: people kept changing the model to explain the experience, but as the model evolved, the experience remained the same. The experience remains empirical.

Osteopathy Yesterday, Today, and Tomorrow

I hope I've conveyed in this book that one foundational principle of osteopathy is its holistic outlook. Several ways come to mind in which that's true. First, classically trained osteopaths view the body as a functional unit, not as a collection of largely unrelated parts. If you come to classically trained osteopaths with debilitating foot pain, for example, we would first attempt to fix the problem biomechanically. The standard medical approach would be to prescribe a muscle relaxer, which could make you sleepy and tired as you attempt to go through your day, or a painkiller, which could give you an ulcer down the road. Generally speaking, a classically trained osteopath won't engage in approaches that create additional problems.

Conversely, the stories in this book have shown that a problem in one part of the body could have its cause in some entirely different part of the body. A classically trained osteopath will have that holistic view of the body and won't fall into the ineffective or even counterproductive trap of focusing too narrowly on just one area or body system. Further, osteopathic methods can mobilize healing processes that function throughout the body in a systemic way. And finally, one more way in which osteopathy's view of the patient is holistic is that we have to be open to all aspects of the human person: body, mind, emotions, spirit. A corollary of the osteopath's holistic approach is that a patient coming to a good osteopath is less likely to be sent unnecessarily to an assortment of different specialists, whose treatment and prescriptions may or may not work well together. Instead, the patient can be treated as he or she actually is: as a whole.

Here's another major principle in how osteopathy views the body and illness, which again is different from conventional medicine: A.T. Still, the founder of osteopathy, directed his followers "to find the health." What is meant by finding the health as opposed to finding disease? Conventional medicine seeks to find the disease, "what is wrong with the body." Finding health requires that the physician "find what is right with the body" and boost it in order to return the body to health and therefore overcome disease.

Let's take the case of pneumonia, for example. If we want to look for disease, we can examine the organism responsible for the infection and attack it with the appropriate medicine. Is this wrong? Not at all, it is appropriate. Is there more we can do to aid in healing? Yes, there is. We can load the body with fluid by increasing intake with juices and water. We can perform lymphatic activation techniques to facilitate drainage of lymphatic fluids to help clear the body of the infecting organism. We can perform lymphatic stimulatory techniques to help increase the body's natural immune response in order to assist the body's natural processes of fighting infection. We can maximize respiratory excursion by freeing bony articulations of the ribcage, thereby helping to expel toxins via the breath. We can release muscular and fascial restrictions of the abdomen, in this way also increasing movement of the ribcage.

Finding the health means working with healthy systems of the body in order to maximize their function in order to restore health. Increasing lymphatic fluid flow, stimulating the immune system, and increasing lung function all help to rid the body of infection. Finding health does not mean to ignore the disease; rather "finding the health" seeks to focus the healing process around the body's own innate healing mechanisms.

A few years ago I was asked to speak about osteopathy on a panel of various practitioners of alternative medicine. I was under the false impression that this august group of practitioners must feel as I do, that the body is a wonderful mechanism full of its own healing powers. Their arts must be based on aiding this mechanism, the body, toward its normal tendency, good health.

Just before my turn to speak on these principles, a chiropractor spoke on how she would help her patients. She related everything that could possibly be wrong with a person to "vertebral subluxations." She said that when vertebrae were "out of correct alignment," dysfunctions would arise. So far, in my head, I said, "Okay, a bit of a stretch to relate *everything* to the spine, but okay." Then she said something that made me feel sick to my stomach. She said, while jabbing her finger at the audience, "Every one of you needs chiropractic treatment every week of your life to maintain perfect health."

I thought to myself, that's it, the pitch for new patients. Once a patient, never to be pronounced healthy. I scanned the crowd and thought, "Are they buying this bullshit?" She concluded, quite proud of herself for scaring the audience into coming in for chiropractic treatment forever. I have since realized that "snake oil" is as popular today as it ever was.

I have not found worthwhile cures in programs whose premise is based on perpetual treatment. The premise of classical osteopathy would be quite the opposite. Dr. Still summarized this point in one of his pithy sayings: "Find it, fix it, leave it alone." The "it" in this case is the problem. In passing, the disarmingly simple assumption in "find it, fix it" is that the osteopath will in fact be skilled enough to find the problem and know how to fix it. You need to know anatomy really well, and you need years of hands-on work with patients to get the knowledge into your hands and your body. Still's statement also implies that when you "fix it," you don't create further problems, as can happen when drugs have "side effects" or when surgery leaves post-surgical complications. The injunction to "leave it alone" reinforces a foundational osteopathic principle: that natural healing processes can and will take over, and must be allowed to do so. And this understanding is communicated to the patient and to the patient's body in part by scheduling treatments more frequently at first, as needed, and then at greater and greater intervals.

The desired goal, of course, is to be able to stop treatment, often after just a few sessions. Certainly in complex cases, like some I've described, treatment has to continue chronically. There are patients who have suffered extremely traumatic events or who are without normal anatomy such that at best they might get some relief but will need continual treatment. But typically, treatment is based on weaning the patient away from the physician, not on regularly scheduled maintenance appointments.

Before I leave the subject of chiropractic, I want to mention another difference between osteopathy and chiropractic as it is often experienced. Osteopaths don't habitually use x-rays to locate a problem before they try to fix it. For one thing, you could get a picture of degenerative joint disease on just about anybody over age thirty-five. That doesn't mean they necessarily need treatment. Even

more important, I think it is criminal to expose a young girl's ovaries to radiation to try to justify treatment of her lower back. I believe that this is done as a sales pitch for treatment many times, but it is important to know that one x-ray of the lumbar spine in a young girl irradiates every single egg that will ever be in her body. Also noteworthy is the fact that the lumbar spine x-ray is one of the lowest-yielding exams; in other words, rarely does this exam show anything wrong ("positive findings"). These problems aside, it is certainly true that many people have obtained relief from chiropractic that they have been unable to get anywhere else, and chiropracty serves a valuable function in our health care system.

As I've said, osteopathy as it has developed in the last several decades is far different then when A. T. Still began the profession. In its roots there was no pharmacology, and insurance was not a consideration. Manipulation was the modality used to restore harmony to the diseased body. To date, osteopathy has been largely absorbed into conventional medicine. Oftentimes a patient may go to an M.D. or a D.O. (osteopathic physician) and be hard pressed to tell the difference.

But it is also true that osteopathy is going through a rebirth. Today, there is a great demand from the patient for something more, something beyond a five-minute consultation and a prescription and out the door. With patient demand goes patient dollars. With dollars goes sudden physician interest. I'm not saying that physicians are only listening to money, but the voice of money is pretty loud. Now we are seeing a resurgence of interest in osteopathic roots. Craniosacral manipulation is enjoying a mass appeal, and this is just one of many osteopathic manipulative modalities.

Craniosacral manipulation was the discovery of a devout osteopath, William Garner Sutherland. He observed the temporal bone of a disarticulated human skull and commented to Dr. Still that he thought it looked like the gills of a fish. He further thought that its shape was indicative of some sort of physiologic movement. Dr. Still, being an avid anatomist at heart, told him to go to it and find out what he could. Dr. Still was known to say "Dig on!" Dr. Sutherland used a football helmet and fashioned it so that he could apply pressure on his own skull by tightening screws on the helmet. He

was very religious and believed that he must carry on his experiments on himself before he attempted treatment on his patients. When Dr. Sutherland presented his original work to his peers in the earlier part of the twentieth century, he was scoffed at. Today we don't often see this kind of commitment from our physicians. I believe that as osteopathy returns to its roots, we will see it blossom in many forms different from the current medical model, and osteopathy will be more accessible to the millions of people who suffer across the U.S. and around the world.

Now more than ever we need osteopathy. Medicine and surgery are great tools, but they're not everything. Currently there are bacteria that are resistant to every known antibiotic. Some researchers believe that the production of stronger antibiotics yields stronger organisms that are resistant to these. There are viruses that remain invulnerable regardless of the trillions of dollars spent. Yet within your body lies the perfect pharmacy with just the right medicines to cure cancer and kill resistant organisms.

Along that same line of thinking, homeopaths have suggested that the current overwhelming viral problems are a direct result of mass pharmacy and vaccination. I have mixed views on this. I don't see all medicines as bad, and quite the contrary I am glad of many of the miracle drugs that are available today. I just don't see them as answering all of our needs. Osteopathy offers a chance for the body's normal healing mechanisms to be restored without pharmacology. Furthermore, much of the world cannot afford pharmacology and surgery. Osteopathy is accessible without a tool bag, without drugs, without even a hospital.

Certain osteopathic modalities are enjoying great popularity today among other therapists, such as craniosacral manipulation, visceral (organ) manipulation, and myofascial release. These techniques have been dissected from osteopathy and incorporated into many other manipulative professions. I see this as progress. I don't believe that the founder of osteopathy envisioned all of the politics that prevail today. I believe that osteopathy is a gift to the world and that it contains elements that are useful in many areas and disciplines of healing. As an osteopath, I feel it is our duty not only to heal but also to teach.

Doctor Fulford once said to me that "focused observation is our most potent tool." He said that when a skilled pair of hands came in contact with the cranial mechanism, via craniosacral manipulation, the most potent form of treatment came from observing and not overpowering the mechanism. He believed that, as physicians, our focusing of attention to the craniosacral mechanism with the intent to benefit the patient helped to empower the already existing healing forces within that person's own body.

The application of osteopathic science requires art. Art is our ability to perceive restriction and states of health and disease in our patients. Art is our ability to blend with our patients, not distance ourselves from them, in order to effect a change. By blend, I mean that we encourage health through gentle technique, rather than overpower the body by surgically removing organs or using pharmacologic agents. The body is far more powerful than anything we can add to it or any procedure we can perform upon it.

What I have witnessed about healing can be reduced to some simple principles. What is required from doctors is, first, they need to have the genuine intent to help, second, they need to have compassion for the patient**,** and third, they need to have the knowledge in their head and in their hands to paint the picture of health in the patient. What is required from patients is the deep desire to heal, not the cortical "I want to live" but rather an expression of the soul. Under these conditions, all things become possible.

II

An Osteopathic Tour of the Body,

Head to Toe

In this section I'll give an overview of how different diseases or dysfunctions are expressed in the body and how osteopathy might treat them. This section is written for a general audience, but it's a technical discussion of how the body works—or doesn't work. A lot of these items are "frequently asked questions" in my practice, things I've needed at one time or another to explain to patients. Obviously, multiple volumes could be written about any one of the topics in this section. I've tried to be brief while remaining accurate.

In the entries that follow, I'm sometimes discussing typical ways that I might treat a given condition. This doesn't mean that in osteopathy there's a cookbook approach to treating any given problem. In any given case, the reason for the problem might be quite different from the generalized situation I discuss below. The osteopath has to be able to discern what the actual problem is, and address it accordingly.

As a tour of the body, these items are arranged, roughly, "head to toe," but that's a framework that needs to be regarded flexibly. By this time it should be clear that a problem in one area of the body may have a cause in some entirely different area. Everybody knows that "the knee bone's connected to the thigh bone," which is connected to the hip bone, and so on. Most people are pretty clear about the fact that tendons and muscles and ligaments are also connected, in different ways, to the bones of our body. Readers may be less generally aware of another structure in the body that I've often had occasion to mention, the fascia. The fascia consists of sheets and fibers of connective tissue that run throughout the entire body, penetrating, surrounding, and separating muscles, organs, and other structures and their component parts. Putting things in their simplest terms, we could say that everything in the body is connected to everything else, often by fascia, so that in theory we could trace a pathway from any one point in the body to any other point.

Another topic that might be unfamiliar to someone new to osteopathy is the fact that appropriate movement of body components is crucial to good health. This is why the term "restriction" has come up so often in my discussion of disease conditions. Restrictions may arise in the body at any level from subtle

to gross, and from any number of reasons—scarring following surgery or healing, force patterns retained in the body from physical or emotional trauma, or disease conditions, for example.

It stands to reason that knees and elbows and wrists have to move freely through their normal range of motion for us to have the full use of these joints. Obviously our hearts have to beat, our lungs have to breathe, and our intestines have to move for these organs to function properly. But throughout the body there are less obvious examples of movement equally crucial to the proper functioning of our body systems. Our bodies are not put together like brick walls. While retaining their appropriate position in the body by means of ligaments or other structures, organs also have to be able to move and slide over each other as our bodies twist, turn, bend, or walk. The fascia that covers our organs helps this sliding to take place, and the quality of the sliding can be affected by whether the fascia is smooth and well lubricated, or rough and dehydrated. If an organ is restricted in its movement or in its own subtle motility (inherent vibratory pattern), its functioning will be affected.

Likewise, if our ribs are restricted in their movement because the cartilage at the points where ribs attach to the sternum is in poor condition, or because the muscles in between the ribs are overly tense, our breathing will be impaired. Even fluids such as blood or lymph or cerebrospinal fluid can be restricted in their ability to move if the vessels they travel in are compromised or if the pressure gradients that drive them are inefficient. Structures such as the bones making up the cranium have to be able to move hundreds of microns at their own appropriate rhythm for the brain and the cranial nerves to function unimpeded. The well-trained osteopath will have many techniques available to remove restrictions and to restore normal functioning insofar as possible throughout the body.

With that background information, we now begin our discussion of different disease conditions in the body "head to toe," with some whole-body systemic conditions placed at the end.

ADD/ADHD

I once sat in on a lecture by a physician quite prominent in the field of dealing with attention deficit disorder and attention deficit hyperactivity disorder. He started out by saying that the longer the name, the less we actually know about the condition. In another context, I learned some very upsetting numbers relative to these diagnoses. One of my patients is a nurse in the Philadelphia school system. She told me that over 60% of the children in her school were receiving a medication for attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), or depression. Staggering, isn't it? I find it difficult to believe that 60% of children in any school could be suffering from these disorders. What I do believe is that if a child's behavior is unruly enough and you go to a few physicians, you will not have to go far to get that first prescription. This is symptom-oriented medicine. It fails to address the cause either emotionally or physically. It seeks to solve the problem by sedating the child.

Now don't get me wrong. I do believe there are cases where these medicines are appropriate, but I just can't believe that more than half of a given group of children suffer because their body's natural pharmacy is chemically deficient.

Ritalin is a drug well known for treating children and now adults diagnosed with ADD. While some of these drug effects are understood on a chemical basis, what is not clearly understood is why children with the same diagnosis do not all respond to these drugs in the same manner. Nor is it at all clearly understood why or how these drugs change behavior. With all the advanced study in the field of neurology involving histology, anatomy, biochemistry and the electrophysiology of neurons, no one has any idea what makes a thought.

With the use of osteopathic manipulation, many children who had been taking Ritalin and other such drugs have been able to stop medication once a cranial strain has been identified and treated. Cranial strains are restrictions in the skull itself or in the dural tissues within the skull and are not generally the sort of thing to show up in an MRI or with any other sophisticated testing. But they can be detected by skilled hands. Cranial strains indicate a decreased range of motion in the cranial sutures or intracranial soft tissues, and can be

treated through gentle osteopathic manipulation.

The Pituitary Gland and the Endocrine System

The pituitary gland has often been referred to as the master gland. It has earned this title because it sends hormones to other endocrine glands, which in turn will create the specific hormone that goes to the relevant end organ. For example, the pituitary gland produces thyroid stimulating hormone, which then goes to the thyroid and requires the thyroid to produce its own hormone to create the end result, which is maintenance of basal metabolism. The pituitary gland is also a progenitor of androgens as well as other ovarian, testicular, and adrenal hormones.

The pituitary gland occupies a rather precarious space in the brain. It is suspended from a stalk called the infundibulum and sits over an area called the sella turcica (which means "turkish saddle"). The sella turcica is bounded by the anterior and posterior clinoid processes of the sphenoid bone. It is directly affected by the cranial motion that occurs at the sphenobasilar synchondrosis (that is, the junction between the occipital bone and the sphenoid bone). A dural sheath encircles the infundibulum. There is an additional process of the sphenoid bone called the dorsum sellae which allows for movement and is thought to go through movements similar to flexion and extension and act as a pump on the pituitary gland. The pumping action would occur during flexion and extension created by the cranial rhythmic impulse (also known as the primary respiratory mechanism). The early theories of the pumping action by the dorsum sellae have been credited to Charlotte Weaver, D.O.

For the most part, people don't come to the doctor complaining of a problem with their pituitary gland. But, as elsewhere in the body, restrictions in the bony or the soft tissue in the area of the pituitary can affect its functioning. These tensions can be released with various techniques of cranial decompression, with resulting effects on the endocrine system throughout the body. Of course, osteopathic manipulative techniques can also be applied directly in the area of any given organ of the endocrine system, such as the thyroid, adrenal glands, or ovaries.

Lazy Eye, Crossed Eyes, and Other Eye-Related Problems

Osteopathic treatment can correct or improve a number of abnormal conditions related to the eyes. "Lazy eye" (amblyopia) is a condition in which one eye, the non-dominant eye, will not track along with the dominant eye. In many cases this non-dominant "lazy eye" will eventually shut down its input to the brain. In this condition as well as with "crossed eyes" (strabismus), we have eyes that do not coordinate properly. The end result can be diminished vision, loss of depth perception, head pain of various sorts, blurry vision, eyestrain, nausea, vomiting, dizziness, and more**.**

Six extraocular eye muscles are intimately associated with movement of the eye and coordination of ocular movement: the inferior and superior rectus, the medial and lateral rectus, and the inferior and superior oblique. Nerves controlling these muscles include the abducens nerve controlling the lateral rectus muscle, the trochlear nerve controlling the superior oblique, and all of the rest controlled by the oculomotor nerve. Fascial strain and/or cranial strain affecting any one of these nerves, either at the brain stem or along their passage in the cranial vault through the dura, can lead to adverse eye movement.

In the suboccipital triangle there also exists fine motor control to modulate alignment of the skull with vision. The suboccipital triangle is that soft space at the back of the head, just above the nape of the neck. You can probably feel the connection between eye movement and these muscles on yourself, though sometimes it's easier to feel it on another person. Put your hands behind your head and move your eyes from side to side and up and down and you can feel subtle muscular movement occurring in that little space. These muscles help maintain your head in a horizontal orientation so that your vision appears level. Abnormal tension in these suboccipital muscles can adversely affect the way your vision is obtained and can thereby force muscular correction in the small oculomotor muscles. The result can often be a tension headache.

Treatment for all these conditions consists of improving the head's biomechanical stability on the cervical spine, as well as bringing about proper fascial and dural tensions within the skull. It is

often possible for "lazy eye" and "crossed eyes" to be completely corrected; the earlier treatment is begun, the better.

Colic and Sucking Problems

Colic is the term diagnosing a newborn who cries a lot and is generally irritable. This is one of the easier problems that I might see in my office. Dysfunction in the base of the cranium—that is, in the general area where the skull joins the neck—will often be responsible for a cranky baby. Compression of the cranium occurs as a natural part of the birth process in order for the fetus to pass through the vagina. During passage, the cranial sutures (the borders where one cranial bone meets another) will become compressed and may even overlap.

When the overlapping or compression persists after birth, this may result in abnormal tension upon the nerves exiting the cranial base. These nerves include the hypoglossal, spinal accessory, and the vagus nerve. The hypoglossal nerve provides control to the genioglossus muscle or tongue. Dysfunction in this nerve can cause problems with feeding and the sucking reflex. The spinal accessory nerve provides control of the sternocleidomastoid and trapezius muscles, in the neck and upper back areas. Too much tension in these muscles causes spasticity in the neck musculature, and too little tension results in poor head control. The vagus nerve is involved in providing nerve supply to the heart, larynx, and most of the gastrointestinal tract, including, necessarily, digestion.

Poor sucking reflex, abnormal head control, and improper digestion are all good reasons for a baby to be cranky. Decompression of the cranium and of the area where the cranium joins the spine will often correct these problems, via release of tension in the muscles and fascia that affect these same nerves.

Recurrent Ear Infections

Chronic otitis media occurs frequently in children and is a condition wherein a child suffers multiple middle-ear infections over the space of several months to a year. After multiple ear infections, children will often be given antibiotics prophylactically. If these fail to prevent further infections, then oftentimes a surgical procedure known as a myringotomy will be suggested. In a myringotomy, a tube is put through the eardrum (tympanic membrane) to help balance the pressure on both sides of the eardrum and to keep fluid from collecting behind the eardrum.

One frequent cause for chronic otitis media is a malpositioned eustachian tube. The eustachian tube provides a communication between the throat and the inside of the tympanic membrane. In adults, this tube is oriented posteriolaterally (angled backwards) and is more likely to remain open and thereby balance the pressure around the tympanic membrane. But in children, the eustachian tube is oriented in a lateral position or tends more to stick straight outwards. This position evolves to the posteriolateral or adult orientation by age five or six.

In a third of the cases I have treated, a gentle fascial unwinding of the tissue around the ear provides enough increased mobility of the eustachian tube to restore normal function and break the cycle of chronic infection. In another third of the cases I've treated, I have been successful with incorporating particular techniques that can be performed at home by the child's parents. These techniques involve some gentle tugging of the ear and can be performed while the child is sleeping.

For a long time I would never demonstrate these techniques without the parents asking me, "Will this make my kid's ears stick out?" Now I usually pre-empt that question by telling them I've never known anyone who needed to consult a plastic surgeon as a result of these techniques.

TMJ

TMJ is an abbreviation for temporomandibular joint. The joint formed by the mandible and the temporal bone of the cranium is quite complicated, with a disc between these two structures. "TMJ" is often the name given any jaw pain or malocclusive problem of the jaw. In and of itself, TMJ is not a descriptive term. It does not tell us the reason for the jaw dysfunction. According to the Piper classification of TMJ dysfunction, any clicking or popping sound is evidence of some level of problem, even in the absence of pain. Causes of TMJ dysfunction include abnormal muscular tension, trauma, bruxism (grinding your teeth at night), and malocclusion, just to name a few.

Of note is the extreme force that the jaw can bring to bear. The jaw can create pressure of nearly 600 pounds per square inch. This type of intermittent pressure just while you were eating a sandwich would grind ordinary bone to dust were it not for the ingenious structure of the skull, which distributes pressure in such a way that bone acts as a conduit for force rather than a recipient of force. Even so, 600 pounds of pressure can do damage enough to the various structures of the TMJ. This pressure is generated by the muscles of mastication, which include the medial and lateral pterygoids, the temporalis, and the masseter. Emotional stress can be a direct cause of increased muscular tension in the masticatory muscles. Stress can also be the driving force behind bruxism. This stress can be cumulative over time. Over time, the muscles involved become hypertrophied (enlarged) and fibrotic (thickened and inelastic). Hypertrophy is a natural response to muscular activity. This is what weight lifters strive for. Fibrosis is quite another matter.

When you put muscles under a strain that they cannot overcome for an excessive period of time, several weeks to months, the muscles respond in the only way that they can. Fibroblasts, cells that make collagen, lay down collagenous fibers within the muscle. These fibers resemble ligamentous tissue, tissue that is tough and inelastic, tissue designed to support weight. Muscles are not designed to support weight; they are designed to move your bones.

But when the stress is removed, the fibrous tissue dissolves. It is there as a response to stress and resolves when the need is there

no longer. Cumulative stress can be unwound using varied digital pressure techniques intraorally. Release of these tissues often releases a flood of emotions as well. The jaw and mouth generally are widely recognized as the avenue of expression; once release is obtained, expression becomes less restricted.

Frozen Shoulder

Adhesive capsulitis, also known as frozen shoulder syndrome, is a condition wherein motion at the joint between the arm and the shoulder (the glenohumeral joint) becomes progressively restricted. This is best demonstrated by having the patient attempt to raise the arm overhead. Since the motion at the glenohumeral articulation is restricted, they will achieve some level of raising their arm overhead by having the scapula (shoulder blade) rotate outward. Adhesive capsulitis usually follows either a physically or an emotionally traumatic event. But in many cases, no event can be recalled, and then the problem is said to be of idiopathic etiology or unknown cause.

What remains is a situation in which the fascia has begun to contract and thereby restrict movement. Let's step back for a moment and see why this is. Keep in mind that all the mechanisms of the body exist for one purpose: to keep you in good health. Many homeostatic mechanisms exist within your body. Homeostasis can be compared to the functioning of a "set point" on a thermostat. If the body gets too hot or too cold, it has mechanisms to return itself to the "set point."

Now, back to the shoulder. When the body has pain with movement of a body part, there are many pathways the body might use to stop or limit that movement and thereby stop the signals of pain. In the short run, this is beneficial because it stops us from causing damage. But in the long run, it becomes disastrous for a plethora of reasons. The primary reason is that the reduced range of motion begets further reduction of motion *and* significant increase of pain with motion as the ligaments, fascia, and muscles become less and less accustomed to motion.

Traditional medical options to treat this kind of problem are quite limited. Painkillers will often be prescribed for the discomfort, but will yield zero effect on the declining range of motion. The surgical option consists of putting the patient under general anesthesia and then having the orthopedic surgeon force the shoulder through a full range of motion, thereby ripping through all of the fascial adhesions. This usually provides several weeks of increased motion, after which the shoulder locks up tighter than ever.

Our bodies respond much better to gentle coaxing than to bullying. Ripping through adhesions under anesthesia causes the body to respond with even greater, stronger adhesions. With the use of gentle myofascial technique, these adhesions can be reduced or eliminated without engaging a compensatory, and in this case deleterious, reaction of further fixation of the shoulder. I find this somewhat analogous to the story of the sun and the wind having a contest as to who is stronger. They demonstrate their strength by challenging each other to see who could make a man remove his coat. The wind attempts to make him remove his coat by blowing harder and harder. Of course, the harder the wind blows, the tighter he clutches his coat to his body. The sun is successful by gentle encouragement, showering heat onto the man, which causes him to remove his coat voluntarily.

Our bodies work the same way. The adhesion exists because, for whatever reason, the body believes that the shoulder motion should be limited. If the body perceives that this limited rage of motion is no longer necessary, then it will send cells that devour collagen to the adhesed area to remove these restrictions. Therefore, the goal is not to rip past these barriers, but rather to remove the tension in the surrounding soft tissues, fascia, muscles, and tendons so that there is no need for joint motion to be restricted.

More Shoulder Problems

Rotator cuff problems involve varying levels of injury to the rotator cuff muscles, the muscles that support your shoulder. Your upper arm can be thought of as being suspended from four muscles that hold the head of the humerus (the long bone of your upper arm) into the glenoid fossa (the hollow in your shoulder blade that receives the humerus). These muscles are the supraspinatus, infraspinatus, teres minor and subscapularis. The action of the rotator cuff muscles, in addition to supporting the humerus and the upper arm in the glenoid fossa, is to internally and externally rotate your upper arm as well as give you the ability to raise your arm in varying directions.

You can think of muscles as being similar to an elastic band, in that if you completely cut this band, there is no form of manipulation that would cause the pieces of rubber band that have retracted to become reattached to each other. But short of having a complete tear through the muscle, which would require surgery to sew the two ends back together again, much healing can occur if tensions in the shoulder are reduced.

Another consideration with shoulder problems is the bicipital tendon, which is a common or conjoined tendon combining the biceps muscle and the supraspinatus muscle. When this tendon becomes irritated (tendinitis), the standard medical approach is first to rest the area or to put on some sort of bracing device to keep the area from moving and to give non-steroidal treatment to help reduce inflammation. If this is unsuccessful, treatment will usually progress to steroidal injections, again to help reduce inflammation but with a stronger method. If this is unsuccessful, then surgical options become available. What is key to look for is abnormal tensions or stresses on soft tissue areas around and about the tendon. If these tensions can be relieved, and often they can, then the tendinitis will resolve of its own accord.

This is not to say that a tendinitis that results from repetitive action will be resolved while the patient continues to do the repetitive action that is causing irritation. What I am saying is that in many cases the body gets caught in vicious cycles. There is some event which causes irritation, which in turn inhibits a tendon or tendon sheath or muscle fiber, which in turn causes more tension, which

causes more irritation, which results in pain. Often that cycle can be broken and function can return to normal in the absence of other continuing exacerbating traumas such as repetitive action motions.

There are four main structures that need to be operating in good health for the shoulder to have its normal range of motion. Dislocations often occur in the glenohumeral joint and in the acromial clavicular joint (or ac joint), where the outer tip of the shoulder blade meets the outer tip of the collar bone. In addition, there must be free motion at the sternoclavicular joint and at the scapulothoracic articulation (discussed below).

When the shoulder goes through a range of motion, it causes motion in all four of these areas. Since the glenohumeral joint and the ac joint are basically where the top of the arm meets the outer edge of the shoulder, nobody would be too surprised to think that these areas might need osteopathic treatment in the case of a problematic shoulder. Less obvious are the roles of the other two structures mentioned. The sternoclavicular joint is the area where the clavicle (or collarbone) comes into contact with the breastbone. The motion there is very small, but quite significant. If there is restricted motion at this joint, you will still be able to enjoy a range of motion, but limitations will begin. You will cause excess movement and irritation at other available joints so that you can continue to try and go through what used to be for you a normal range of motion. Over time, this will progress and worsen to the point where pain or disability occurs. Usually most people seek help with a problem only when dysfunction and pain have progressed to the point of truly interfering with their daily activities.

The fourth area to address is that of scapulothoracic motion. The scapula (the shoulder blade) does not have a "joint" per se with the thorax, but the shoulder blade does go through various movements and rotations over the posterior aspects of the ribcage. Restrictions or adhesions in this area can very often produce what is known as crepitus. Crepitus refers to cracking and crunching sounds that people will hear or feel when they move certain joints about. Crepitus may or may not be painful, but is always indicative of some sort of restriction either in the soft tissue or in the bony tissues. As always, restrictions will eventually cause dysfunction, in either the

immediate area or related areas.

Visceral concerns arise in connection with shoulder dysfunction as well. There are many interesting links between your internal organs and your joints and muscles, associations that are not commonly looked for. In the abdomen we can think of all your internal organs, such as liver, stomach, colon, and so on, as organs that go through motion as your diaphragm goes up and down with respiration. These organs are suspended from soft ligamentous structures that help them maintain their position in the abdominal cavity, and the organs slide and move about other internal organs in fairly standardized patterns. When these processes are disturbed either via surgery, other traumatic events, or even post-surgical healing, their motion in the abdominal cavity can be altered.

This altered motion can in turn affect muscular structures. This is not a difficult concept to grasp once it's explained, but the connection is not one that's commonly thought of. Here are a couple of examples that will take us back to the subject of the shoulder. Among the many suspensory structures involved in containing the liver in the abdominal cavity with respect to other organs are the right and left triangular ligaments. If we reduce this issue down to its simplest terms, we can trace the ligaments which support the right lobe of the liver back to structures on the inside of the thorax near the right shoulder. In many cases you can treat a right-shoulder problem by addressing structural components of the liver with deep visceral manipulation. Likewise, the stomach, which occupies the left abdominal area, may be associated with left-shoulder dysfunctions.

Post-Mastectomy Trauma

Breast cancer is a major killer of women in the United States. Often this cancer spreads sufficiently such that a radical mastectomy is indicated. In this situation, not only is the breast removed but also the lymph nodes and lymphatic vessels that drain the breast. The tail of the breast and the lymph tissue are found in the axilla, or armpit. This operation usually results in a massive, tight, purple scar across the chest and into the armpit. What we have now is an arm without a lymphatic system.

What does the lymphatic system do? The lymphatic system, composed of vessels, nodes, and organs, is responsible for fighting viruses and bacteria, aiding in digestion by absorbing fat-soluble substances, and moving extracellular fluids, thus facilitating cellular nutrition and waste removal.

Consider that your body has approximately five to six liters of blood, or somewhat more than the same number of quarts. There are an additional forty-two liters of other fluids inside and between individual cells of your body. The heart is responsible for pumping blood throughout your body. And the lymphatic system, powered by the muscular system, is responsible for pumping these other forty-two liters of fluid throughout your body.

What do we notice when the lymphatic system is removed? The arm blows up like a balloon, except that it's full of accumulated fluid, not air. In women who have had a radical mastectomy, their arm can be the size of their thigh. A frequent complaint is that they can't wear the same size clothes because their arm won't fit through the sleeves. The most common complaint is exquisite burning pain in the swollen arm.

The conventional medical solution to this problem is a machine that functions like a sequential blood pressure cuff by inflating a cuff near the hand and then deflating and inflating closer and closer to the shoulder. In this way, some of the lymphatic fluids are forced into venous (blood) circulation and out of the arm. This, of course, only works temporarily while the machine is in use.

An osteopathic approach to treatment consists of first trying

to find a way to restore normal anatomy. Well, the breast is gone, so what can we restore? Is the scar normal? Of course not! Although the scar is necessary to close the incision, scars will often "stick" to other tissues and interfere with nerve and blood supply, which was not the original purpose of the scar. Medical doctors call these "sticking" areas adhesions and look at their sequelae (what happens after) as normal and acceptable.

Adhesions are not normal anatomy, and they are not acceptable post-surgically. These can be removed or lessened in severity via direct myofascial pressure techniques. These techniques do not give a woman without lymphatics a normal arm, but they do allow for maximum drainage via the venous system without the impedance of scar adhesion.

Beyond breaking up of the scar adhesion, further osteopathic treatment after a radical mastectomy would include manual sequential drainage techniques for the arm and torso. In the "whole-body" approach characteristic of osteopathy, drainage of the torso will cause siphoning of the fluids trapped in the arm. Because the normal anatomy is gone, such treatment would have to be repeated periodically.

Elbows, Forearms, and Wrists

In the elbow, two areas in particular tend to become problematic. The area that we commonly think of as our elbow is called the olecranon process. On either side of this are two large bumps that are called the medial and lateral epicondyles, the medial epicondyle being on the inside and the lateral epicondyle on the outside. These epicondyles or bumps on the bone are formed from muscle groups exerting pressure on the bone at the point where they attach. The muscle groups that originate from the lateral epicondyle form a group known as the extensor compartment. When this area is in dysfunction, the problem is commonly known as tennis elbow. The medical name is lateral epicondylitis, which simply states that there is irritation in the area of the lateral epicondyle. It's commonly referred to as tennis elbow because these are the muscles that you would use while doing a backhand type of stroke.

On the other side of the elbow, the medial epicondyle, is a site of muscle attachment for all the muscles of your forearm that are involved in flexion of the hand. Such flexion includes actions that would be commonly mimicked while golfing, and when this area is in dysfunction the resulting problem is referred to as golfer's elbow. The medical term for this would be medial epicondylitis. Both tennis elbow and golfer's elbow can be corrected via osteopathic manipulation that restores normal function to the affected areas.

When treating any disorders of the elbow, forearm, or wrist (or even further down to the hand or further up to the upper arm), it is important to remember that many connections between one section and another in this area of the body are indirect rather than direct. Their complex arrangement is what allows for free and intricate use of the hand and arm. For example, the two bones of the forearm are the radius and the ulna. The radius, located toward the thumb side of your hand, has a firm articulation of interaction with the wrist, while the ulna does not directly interact with the wrist, although it does interact with the radius near the wrist. At its other end, however, the ulna forms the olecranon process (the elbow), and this projection in turn forms a joint or articulation with the upper arm or humerus, whereas the radius does not.

In order to transfer forces from the hand to the upper arm, therefore, we need to cross from the wrist to the radius to the ulna to

the upper arm. How is this done? The transfer is accomplished through soft tissues, chiefly the interosseous membrane that connects the radius and the ulna. Why is this significant? The significance is this: there are many complicated relationships in the body that do not appear readily by putting the area of pain under a microscope and saying, "Well, this must be the problem." There are many reasons why a problem area can be distant from the problem's cause. This is why it is necessary to look at a person in a holistic context, holistic referring to the entire person and not just the area of complaint.

A well-known problem in this region of the body that illustrates this point is carpal tunnel syndrome. If we look at the anatomy of your hand, first looking at the palmar surface, we would note a tight band of tissue over your wrist, called the flexor retinaculum. Underneath this tough tissue go all of the tendon sheaths that help to flex your hand, plus a nerve known as the median nerve. True carpal tunnel syndrome results when these tendon sheaths become irritated and therefore swollen and inflamed. This tunnel is bounded by the radius and ulnar bones, along with the flexor retinaculum as a tough roof. When the tendon sheaths become inflamed, there is no room for expansion, so what follows next is compression along the median nerve. This typically involves pain and paresthesias (abnormal nerve sensation such as burning, numbness, prickly feeling, pins and needles) along the thumb, second, third and sometimes fourth fingers.

Treatment options for this condition usually involve surgery, but this surgery fails at least fifty percent of the time. If in reality there had been compression along the tunnel and the roof of the tunnel were surgically cut, then the pain of carpal tunnel syndrome should no longer exist. The fact that it often does persist after this surgery indicates that the condition was misdiagnosed, or that other overlapping problems have not been diagnosed. In fact, carpal tunnel syndrome is often confused with thoracic outlet syndrome and other impingements on nerves coming from the neck to the shoulder, elbow, and forearm. These conditions as well as true carpal tunnel syndrome can be addressed via osteopathic manipulation. Many of the symptoms of carpal tunnel syndrome come from the swelling in the tendon sheath. If the swelling is reduced, so are the symptoms. Obviously it's preferable to relieve the condition via

manipulation and avoid surgery if possible.

Carpal tunnel syndrome is frequently induced by repetitive actions. Certainly these traumas need to be addressed, just as treatment needs to be given for the ongoing condition.

Severe Digestive Problems in Children and Adults

Baby-care books with a medical slant will usually have an entry on "projectile vomiting," vomiting so forceful that the child's food spews out several feet in front of him. Projectile vomiting can be caused by structural abnormalities in the digestive tract, such as pyloric stenosis, volvulus, or intussiception. These conditions (described below) very often become surgical emergencies. But early detection of the associated tissue changes in the abdominal fascia means that the problem can be addressed through gentle manipulation. In cases that have already gone through surgery, the complicating sequelae can often be addressed as well.

The pylorus is the lower third of the stomach where digested matter flows from the stomach into the first part of the intestines. A stenosis refers to a narrowing of that passageway. An infant with pyloric stenosis will often have projectile vomiting because no food is passing through the pylorus. Volvulus is a twisting around of the small intestines, while intussiception is a collapsing of the intestine upon itself. In all of these cases, digestive functioning is severely affected, to the point where surgery or other endoscopic procedures may be considered. Endoscopy involves putting a large tube through the stomach directly into the pylorus in order to enlarge the closed area.

In all of these conditions there will be significant increased tension in the abdominal planes of fascia that surround these structures. I am not suggesting that a case requiring immediate surgical intervention be postponed for manipulation. I am suggesting, however, that before the symptoms become so severe that they require surgery, many of these tissue changes will be readily palpable upon examination and treatable with gentle manipulation.

Dysfunction in the body can be thought of as a ripple in a pond. At first, changes will be observed at the area where the problems are occurring. As time goes on, the body will recruit structures further and further away that are required to change as a result of that initial ripple in the pond. Because babies cry when they're in pain, and because children very often have adults doting on them, and because parents generally pay more attention to their children medically than they do to themselves, a child is more likely

than an adult to be treated in the acute phase. This early treatment is likely to be successful because children haven't had time for chronic dysfunction to set in.

When we're adults and we have abdominal fascial dysfunctions such those associated with ulcers or irritable bowel, these may progress for months or years before being treated with medicines and then multiple surgeries. The situation can reach the point where the patient begins to complain of backache and hip pain that can largely be due to soft tissue changes. That is, the original ulcer or irritable bowel has begun to make the surrounding tissues hypertonic (overly tense) or fibrotic (streaked with fiber amidst the organ tissue, muscle tissue, or other soft tissue). By this point the patient has "a bad back" or "a bad hip," but these are not the underlying problems, they are secondary to the original organ problem. Happily even these complications can be treated via manipulation. But how much better to identify the problem early on with palpation, and correct it with manipulation.

Going the standard medical route, someone with ulcers or irritable bowel syndrome would see an internist. The problem may be relieved with medication, at least for a while, but it may develop to the point where surgery is recommended, and then the patient goes to a surgeon. Finally, as a result of post-surgical adhesions, our patient develops "a bad back" or a hip problem, and finds himself knocking on the door of, most likely, an orthopedic specialist. The three separate problems with the three specialists are really just one problem when seen from the osteopathic point of view, which regards the body as a holistic unit. With successful osteopathic treatment of problem number one, the second and third need never arise.

Back Pain

Back pain is an enormous topic. Volumes of information have been written on lumbar pain. We see terms such as sciatica, lumbago, disc herniations, disc bulges, radiculopathy, neuropathy, and sacroiliac strain, just to name a few. Some of these names describe the distribution of pain. Some describe the set of symptoms. Some describe effects of a mechanical overload, and yet some just describe that someone's back "hurts." So what's in a name? Different names don't really point me to what the actual problem might be, or how it might be relieved. This is where osteopathy can help. Let me take this further. Let's say, for example, that someone is suffering with low back pain following a disc herniation that has resulted from a mechanical overload. Let's also say that they have pain running down through their buttocks and into their hamstring muscles.

In all likelihood they will have an MRI that reveals the disc injury. Depending on the severity of their discomfort, an orthopedic physician may recommend epidural injections or surgery. When these options do not yield results, the patient is left with long-term non-steroidal anti-inflammatory drugs, muscle relaxers, and narcotics as a sloppy solution.

However, very often these same patients may become symptom-free with gentle osteopathic manipulation. What you must keep in mind is this: Manipulation, of any kind, will never restore the disc to its pre-injury state, but osteopathic manipulation may relieve the symptoms by restoring normal tonicity to the surrounding musculature. The surgeon offers surgery because an MRI reveals a damaged disc and therefore this must be the problem. In a myopic view of dysfunction, if your only tool is a hammer then everything you see is a nail. I don't fault surgeons for looking for surgical solutions; it's what they know how to do. So, if the disc is damaged and surgery is not necessarily the answer, then how can the problem be resolved with manipulation if the manipulation does not alter the disc? Yet this has been proven many times case by case.

Let's first examine what is meant by a herniated disc. The vertebrae in your back are separated from each other by a disc. The purpose of this disc is to bear weight. This disc has a gelatinous

center called the nucleus pulposus, which is surrounded by a very tough fiber called the annulus. When a disc becomes herniated, the nucleus (soft material) has burst through the annulus (tough material) and may press on nerves exiting the spine that send pain to the back, buttocks, hips, and legs.

Once the nucleus has ripped through the annulus, it will never go back in. You can think of it as though you might try to put toothpaste back into the tube. It's not going to happen. So surgically, there exist many options to attempt to deal with this situation.

What is the situation? It is this: a mechanical overload has caused the disc to extrude through the annulus. This may or may not put pressure on the spinal nerves. There is disruption to the fascia and musculature in the surrounding tissue. This disrupted fascia and musculature may in turn put pressure on nerves that pass through them, thereby further contributing to the end result of pain.

Many times the pain that results from multiple inputs such as disc damage, inflammation, muscle spasm, and so on can be resolved by using simpler, non-surgical options. With gentle osteopathic manipulation, often proper muscle tone can be restored, thereby relieving pressure on peripheral nerves and stopping the pain without the need to alter the damaged disc via surgery.

Premenstrual Syndrome

PMS is frequently a reason for women to be "bitchy." Sometimes we have come to accept this behavior as normal. Women expect that back pain, cramping, and depression or fits of rage are okay a week or two before their period. We have plenty of comedic material that reflects this as average or normal behavior.

Menstruation is the normal process of the sloughing off of the uterine lining. This lining becomes thicker throughout the cycle to prepare for the event of an implanted embryo. When implantation does not occur, the lining sloughs off and the cycle begins again.

It is not normal to experience back pain the week before or during menstruation, although it is common as evidenced by the shelves of medicine in the drugstore dedicated to this problem. Impulses from the viscera, in this case the uterus, reflect back to the spinal cord and can excite neurons at the same level of the spinal cord that sends information to muscles as well. These muscles can then perceive this sensation as pain even though they are receiving stimuli indirectly from the uterus and not from actual irritation of the muscles themselves.

As to "bitchy," new lines of medication have, in recent years, become indicated via the U.S. Food and Drug Administration (FDA) for this condition. Selective serotonin re-uptake inhibitors (SSRI's) have been the new soup du jour for a chemical attitude adjustment in a woman who presents to her doctor with this complaint. Zoloft, Prozac, and many others are routinely prescribed for women with these supposedly psychological complaints.

I would suggest, however, that were men to have cramping sensations in their backs one or two weeks every month that they might exhibit "bitchy" behavior as well. So, what to do about it? Since the back muscles perceive irritation via uterine nervous input, conversely we can reduce the overall nervous input and reduce muscular irritation with gentle osteopathic manipulation, such as cranial technique, myofascial technique, muscle energy, or counterstrain technique.

It is impossible to separate the mind from the body. To do so

is a western mode of thought. Any physical problem, over time, will begin to take its toll on our psyche. Any psychological disturbance, over time, will manifest physical symptoms. So how does conventional medicine deal with this? By chemically altering the psychological outcome or the exhibited behavior. This fails to treat the root of the physical discomfort. Fix the physical discomfort and you fix the problem.

Sexual Dysfunction in Women

The complaint of painful intercourse is called dyspareunia. Unfortunately, many women silently endure this condition and accept it as normal. So too with anorgasmia, or the inability to reach orgasm, another abnormal condition.

Often painful intercourse results from the penis hitting non-compliant structures in and around the vagina. What I mean by non-compliant is this: the structures that support the walls of the vagina and the uterus, and that allow for uterine and cervical movement, should have some laxity or give and take. When these supporting ligaments do not have give and take, then vaginal penetration causes an inordinate disturbance in the pelvic fascia, which can be painful.

Another factor contributing to dyspareunia can be vaginal dryness. This can result from a variety of reasons, including decrease of the nervous stimulation that causes secretion. Vaginal secretions are stimulated by the involuntary nervous system, in particular the part of the involuntary nervous system that causes your body to be in a vegetative state (the state in which your body increases digestion, slows down the heart and blood flow, and may become sexually aroused).

The relevant nerves can be accessed over the sacral and/or tailbone area. Restriction in the fascia over these nerves can decrease the stimulation the nerves transmit to the pelvis. Their function can be improved or restored by releasing the relevant fascial restrictions. In addition, supporting tissues in the pelvis can be restored to freer movement when addressed via gentle manipulation on the outside of the pelvis.

There are many factors that result in an orgasm, emotional and physical, but certainly it helps to have the physical foundation in place: a normally functioning nerve supply, good blood flow, and ligaments that both support the pelvic structures and allow them appropriate mobility.

At the Tail End

By this time you might not be surprised to learn that your coccyx could have a lot to do with many aspects of your health, as a classically trained osteopath would know. The coccyx, or tailbone, is the last segment of your spine. It has a very fragile articulation with the large bone directly above it, the sacrum, which is susceptible to injury when you fall onto your buttocks. This is also an area heavily supplied with nerves of the parasympathetic nervous system, the nerves responsible for many of the body's fundamental vegetative activities. Parasympathetic responses include increased digestion, decreased heart rate, pupil constriction, sexual arousal, and more. Because of all the important bodily functions affected by this area, it is imperative that the position and range of motion of the coccyx be assessed, especially when all other medical examination fails to diagnose or recognize injury.

I examine the sacrum and coccyx in every patient. I feel that these areas are so commonly overlooked that I always address these areas even in the absence of a direct complaint.

Correct sacral biomechanics are important for proper pelvic floor stability. Incorrect mechanics can be a cause not only for bowel and bladder incontinence, but also for dyspareunia (painful intercourse), infertility, constipation, abdominal pain, PMS, painful menstrual cramps and more. In young children, dysfunction or malposition of the coccyx can result in bedwetting. I frequently treat bedwetting as a secondary complaint. Parents don't usually bring their child to an osteopath to cure bedwetting, but rather often I will treat a child for some other problem and the parents will note that their child suddenly stopped wetting the bed, "for no apparent reason." However, the reason may be quite apparent to someone trained in osteopathic manipulative medicine. Neurologically, myelination of the peripheral nerves can take eight years or more. Delayed or incomplete myelination is one reason to wet the bed. Emotional trauma is another. But often overlooked and frequently involved are sacral and coccygeal dysfunction.

Knees: How and Why They Can Heal

The knee is a complicated joint, involving many structures such as the meniscus, cruciate ligaments, collateral ligaments, and so on. All of the structures in the knee are certainly important to its health, but when there are knee problems, one must also look above and below it, at other joints that alter the normal biomechanical gait. In order to examine the knee, you must also examine the hips and ankles, as abnormal stress in these joints can adversely affect healthy operation of the knee joint. This osteopathic perspective, which looks at the body as a unit rather than as individual parts, is important whether the knee is not functioning well simply because body mechanics have been disrupted, or because there is actual injury that needs to heal.

The knee has various ligamentous structures that help to keep it stable during movement. Structures that keep the knee stable during flexion and extension, or what we commonly think of as bending and straightening our knee, would be the anterior and posterior cruciate ligaments. These are very thick strong ligaments. Other ligaments help stabilize the inside and the outside of the knee joint against lateral destabilization, known as the medial and lateral collateral ligaments. Two menisci, which are very thin soft disc-shaped wedge-like structures in the knee joint on either side, help modulate the knee's motion. These menisci are often torn in traumatic movement to the knee, as in many sports injuries.

The job of ligaments is to keep an area stable. Ligaments help guide the action of muscles by keeping the bones aligned together while the knee goes through a range of motion. Ligaments typically are on tension. When ligaments are off tension or in a state of hypermobility, they are unstable and quite painful. Unstable ligaments can be addressed through the use of sclerotherapy, which involves injecting an irritating type of solution along the ligamentous insertions. The irritating solution causes a reaction so that the body lays down fibrous tissue along the ligament, thereby strengthening it. This procedure is obviously somewhat different from most of those I've been discussing, in that it does more than simply restore normal anatomy. It remains within the osteopathic perspective, however, in that it uses one of the body's own mechanisms, the ability to create fibrous tissue, in order to correct a problem. This procedure can be a

viable alternative to surgery.

Tears in the meniscus are another matter. Within these wedge-like structures, there is a vascular zone and an avascular zone, that is, the first with a blood supply, the second without. Typically if someone suffers a mild to moderate tear in the vascular zone, it will heal of its own accord with rest. It is commonly thought that a tear in the avascular zone will not heal because there is no blood supply to facilitate healing. There is, however, supply of nutrients to the avascular zone, but not via the blood. It comes via osmotic flow through the synovial fluid, the fluid that lubricates the knee joint and other joints of your body. This perspective on healing stems from the founder of osteopathic medicine Andrew Taylor Still, who firmly believed that the body did possess its own mechanisms of healing. The contemporary thought that there are areas of our body that are inaccessible to healing or that are composed of inert materials that just kind of sit there is ridiculous.

One thing that has been observed in science is that as we examine something more closely, the more powerful microscope, the more powerful telescope always shows us a more complicated picture. Never do we examine something further and find that things are just random or chaotic. But the assumption is made in conventional medicine that we have areas of our body that were somehow put together without a thought to maintaining their good health.

A tenet of osteopathic thought and treatment is to be aware of the body's capacity to heal, and always to look for the health rather than the disease in the body. Philosophically speaking this sounds good, but modern western medicine has not for the most part been based on the belief that this is the right approach. Nevertheless, I have observed cases of tears in the avascular zone of the meniscus that have healed with proper rest and restoration of normal biomechanics.

Shinsplints

Shinsplints, also known as anterior compartment syndrome, can result from severe stress on the front of the lower leg, in particular on the tibialis anterior and associated muscles in the anterior compartment of the lower leg opposite the calf muscles. This is a common sequela for joggers and runners. Treatment for anterior compartment syndrome consists of applying myofascial release and counterstrain technique to the anterior compartment to relieve pressure and restore normal biomechanical function. Myofascial release is a technique that involves direct pressure on the muscle itself, whereas counterstrain involves bringing the muscle bellies' origins and insertions toward each other to take the muscle off tension and thereby reduce spasm and strain.

Plantar Fasciitis

Plantar fasciitis is a condition in which the fascia on the plantar aspect of the foot, the sole of the foot, has become irritated. This can be for a variety of reasons, including fallen arches, poor shoes, ambulatory dysfunction, sedentary lifestyle, or sequelae of collagenous disease; or it may be what we call idiopathic, without a known cause. Plantar fasciitis manifests as pain in the bottom of the foot, which is exacerbated with walking. Most sufferers note that the pain is greatest in the morning hours, worsens with initial walking, and decreases as the day goes on and they've been moving around a while.

It is interesting to note that many consider plantar fasciitis to be the sequelae of either high arches or flat feet and that if you just had a correctly shaped arch, there would be no problem. What is not taken into consideration is that perhaps the arch was not meant to be static, or in one fixed position. It has been observed in native populations that do not wear shoes that the arches change with movement. When they are in motion, the arches become high. When they are still, the arches become flat.

Osteopathy always seeks to find a relationship between form and function. In other words, when we observe a function, there must be a form associated with that and vice versa. Can you think of an advantage for high arches while you are in motion and an advantage of flat feet when you are just standing? When you run, you place three to four times your body weight on your feet, thus the need for an arch. An arch is able to sustain pressures much greater than a flat structure can. When you stand in place, there is no need to sustain amplified pressure, and so the flat foot allows greater contact with the ground and thus greater balance.

So you see your body has the ability to weigh the needs of balance and pressure and to vary its response via the arch. Perhaps much of our foot problems are the result of a fixed arch that comes from footwear and the loss of the body's natural accommodation to its surroundings. Am I suggesting that you throw your shoes away? No, I'm not; I wear shoes, but it is helpful to wear shoes that provide support while allowing flexibility in the arch.

Plantar fasciitis is treatable with several forms of osteopathic manipulation including myofascial release, craniosacral manipulation, muscle energy technique, functional technique, facilitated positional release, and counterstrain technique.

Fibromyalgia

What is fibromyalgia? Well, according to modern medicine, there exist eighteen points on the body to be examined. If we push on these eighteen points and eleven are tender, then the patient has fibromyalgia. Additionally, most of these patients will have an elevated sedimentation rate when their red blood cells are examined. An elevated sedimentation rate merely means that you have inflammation somewhere in your body. There is no specific blood test for fibromyalgia. Fibromyalgia is conventionally treated as this somewhat amorphous condition, theorized to be of viral or genetic origin.

Clinically, a correlation has been made between chronic fatigue, depression, and fibromyalgia. Who is surprised by this finding? People who suffer from fibromyalgia have a great deal of pain and so they expend more energy to do the same activities as healthy people, ergo, they become fatigued quicker. Because they have pain and because they fatigue quicker, they become depressed. Does this seem like a surprise now?

What is obvious to a trained pair of hands is that these individuals truly have tension locked in their fascia. Fascia envelops every fiber of your muscles and gives the muscles shape in order that they may function properly. Fascia has a tensile strength that is functionally about sixty times that of bone. It has piezoelectric forces as do LED wristwatches. Fascia is responsible for transmitting electrochemical substances. It has blood and nerve supply dedicated to its function as well.

Tension in the fascia can be released with many forms of gentle osteopathic manipulation. Unfortunately, many people who suffer with fibromyalgia undergo treatment with non-steroidal anti-inflammatory medicines, narcotics, and anti-depressants with minimal success.

Depression

Some people are depressed because depressing things have happened to them.

The new class of medical wonder drugs for depression is the selective serotonin re-uptake inhibitors known as SSRI's. What's known about these drugs is that they increase the amount of serotonin in the brain. What is not known about them is how increased serotonin in the brain lifts depression. What happens clinically is that patients get prescribed one of these medicines with the hope that their depression will resolve. If the medicine fails, patients continue to try a potpourri of one after another of these types of medicines, often prescribed from a variety of specialists.

Your body can be thought of as an audio, visual, and a proprioceptive recorder for all of your life's significant events. In addition to changes in your brain that can be measured pharmacologically such as serotonin levels, we can observe and palpate many tissue changes throughout the body that accompany depression as well.

Certain changes in the dura (a thick covering of the brain and spinal cord) are known to be common in depressed people. Because the dura is firmly attached to the skeleton at certain locations within the skull and also at the sacrum, increased dural tension causes lumbosacral compression in the low back as well as occipital-atlantal compression at the base of the skull and sphenobasilar compression within the skull.

I'm not suggesting that depression is caused by physical tissue changes such as tension, but an emotional state of depression absolutely leaves a physical imprint in the dura and the fascia. Whatever we don't deal with emotionally, we somaticize. Treating the fascial strain throughout the body and any compression at the lumbosacral, occipital-atlantal, and sphenobasilar areas may clear the body of accumulated stress and make depression more amenable to adjunctive therapy.

Pain

Pain is multifactorial. There are many reasons for pain, not all of which are readily apparent from the traditional medical viewpoint. For this reason, traditional medicine treats pain with painkillers. But let's take a larger view, shall we?

Let's take the case of someone with a fifth-lumbar herniated disc. A herniated disc is a situation wherein the disc material, the material between our vertebrae, the stuff which bears our weight, has broken out of its container and very often presses on the surrounding nerves, causing pain or muscle weakness.

As I've said earlier, you can think of this as toothpaste come out of a tube, you're never getting it back into the tube once it's out.

This "stuff" now presses on nerves, and the pressure causes irritation to everything that the nerve goes to, skin, muscles, internal organs, et cetera. How does this feel to the patient?

The patient's complaint may be one or more of the following: "My leg burns, it aches, I've got stabbing pains in my back, my bowels are constipated, I have diarrhea, my foot is tripping on the carpet" (a sign of muscle weakness). Okay, you get the picture.

This nerve irritation in turn causes inflammation of the muscles surrounding the nerve.

Over time, the muscles change from the inflammation-induced spasm to chronic fibrosis. As previously discussed, when muscles have excessive demands placed upon them, they become braced with streaks of fibrous tissue that will support weight, but the fibrous tissue can't elongate or shorten. This fibrosis in turn begets decreased range of motion, and the patient requires increased energy output to perform the same activities as previously, such as walking, doing chores, etc., what we call ADL's (activities of daily living).

If your ADL's become more difficult AND you are in pain, you get depressed. What a shock....to come to this conclusion! You're tired from having to put out all the extra energy just to get through the day, and you're depressed.

You go to your doctor and he or she tells you, "You are afflicted with fibromyalgia, which is a genetically inherited painful condition associated with fatigue and depression."

You are then treated with Prozac for the depression, various narcotics to deal with your chronic pain, and stool softeners to deal with the constipation brought on by decreased activity and the side effects of narcotics. Pills, pills, and more pills to deal with the side effects of the pills.

Somewhere further down the line, someone offers you surgery, which for the back generally has a poor batting average.

Eventually due to your decreased ability to meet the demands of your life, family and job, in comes the psychiatrist to help you with your mental problems.

This is utter nonsense.

Let me first clarify that I do see an appropriate time and place for surgery, pills, and addressing mental health issues, but all too often patients are pushed down this dark road too quickly and without cause.

No one is getting the toothpaste back into the tube, not the surgeon, not the psychic healer, and not myself, but that does not mean that all of this pain and the cycle of pain cannot be broken.

You can have a herniated disc and have no pain; it is possible. If an x-ray or an MRI shows a herniated disc but you have no pain, you might not want to leap immediately to surgery to correct the herniated disc.

But let's say you do have pain. In the acute phase, that is, just after the toothpaste comes out of the tube, there is significant swelling and spasm of the musculature. The depression and fatigue have not become a daily feature of your life at this point.

There are many techniques the osteopath can use in this situation. Counterstrain, myofascial release, craniosacral work and other techniques may break the spasm. Lymphatic techniques may help reduce the swelling. The cycle of pain and inflammation can be

broken. Nothing is guaranteed, but there is a good chance of effective intervention before surgery begins to look attractive or psychiatry becomes the only recourse.

As I have stated, there is an appropriate place for all of these medical modalities, but in our world, or in the surgeon's world, if you have a herniated disc then you need surgery. It's what surgeons do. Again it's that old saying, "if your only tool is a hammer, then everything you see looks like a nail." If you're a surgeon, then you offer surgery; if you prescribe pills, then this is what the patient can expect.

Osteopathy, true classical osteopathy, offers a wider range of possibilities for pain relief because it seeks to activate and to work with the body's own healing mechanisms to reduce swelling and stop muscle spasm. It's worth a try before lying on a cold table under a sharp knife.

ABOUT THE AUTHOR

Steven A. Sanet, D.O., founder of the Osteopathic Health and Wellness Institute (OHWI) and of the Osteopathic College of Ontario (OCO), is a native Philadelphian and a graduate of Nova-Southeastern University of the Health Sciences College of Osteopathic Medicine, where he completed a fellowship in Osteopathic Manipulative Medicine. Additionally, Dr. Sanet was residency trained in Osteopathic Manipulative Medicine at the Philadelphia College of Osteopathic Medicine. Dr. Sanet teaches Osteopathic Manipulative Medicine to medical students, interns, and residents, in addition to practicing and teaching at OHWI and OCO.

Always a voracious learner, while attending medical school Dr. Sanet also took part in extensive extracurricular studies, during which he met the renowned osteopath Robert Fulford, D.O. It was through meeting Dr. Fulford that Dr. Sanet was inspired to follow the path of a true osteopathic physician, much against the dominant trend in medicine.

Since making the commitment of caring for patients as an osteopathic physician and as an instructor of osteopathy, Dr. Sanet has built up an enormous following of patients and practitioners. In pursuit of his medical practice and teaching career, Dr. Sanet has also received many honors and distinctions. From 2004 through 2006, Dr. Sanet served as Chairman of the Credentials Committee of The Cranial Academy, a Component Society of the American Academy of Osteopathy.

Prior to attending medical school, Dr. Sanet had been accepted as a member of American Mensa, Ltd. and graduated Summa Cum Laude in Pre-Medicine from The Pennsylvania State University. Additional honors include Phi Beta Kappa, Phi Kappa Phi, and Alpha Epsilon Delta.

As a youth, Dr. Sanet took a keen interest in martial arts, where he has attained black belts in over eleven disciplines. Dr. Sanet continues as an avid martial artist today.

Dr. Sanet has been the keynote speaker for the British Osteopathic Association, the Australian Osteopathic Association, the Finnish Osteopathic Association, and the International Osteopathic Congress in Brazil. He has lectured frequently in many parts of the world, including at Shingu College in Seoul, Balgrist University in Zurich, Hong Kong, Helsinki, Venice, Rome, London, Tokyo, and across the United States.

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ISBN 9781508757061
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