Academy of PHYSICAL MEDICINE

Transcript

Spinal Oscillation With Tim Sparrow

Cast List

Steven Bruce	S
Tim Sparrow	T
Kate Walton	K

S: I'm joined this evening by Tim Sparrow. Tim is a chairman and a senior lecturer at the Institution of Classical Osteopathy. He was, in the day, trained by John Wernham himself. Now, the name John Wernham will be known to all osteopaths watching this evening, but if you are actually a chiropractor, then Tim will explain himself. This is one of the biggest names in classical osteopathy, and it's a serious attribute to have been trained by the great man himself. Tim is widely read, widely researched, widely traveled. He's based in Belgium, and he's got an enormous amount of experience in different fields of treatment using classical osteopathy. But actually, Tim, good evening.

T: Hello. Nice to meet you.

S: Why don't you tell us what it is that you do? Because you've done pre and postpartum treatments, haven't you?

T: Yes. I worked in Holland from 2002 to about 2009 in a midwifery clinic as an assistant osteopath there. That was really nice, enjoyable. Working with pre and postnatal care, follow-up.

S: Why Holland?

T: That was where I was living. Well, a 2000, millennium decision, and I decided to move with my ex-wife ... at the time we were married. I just was part of the idea of developing the concept of osteopathy with other people. They have a register there, which was nice. Actually, John Wernham went there, and he was actually on television to promote the profession. And 2000 we had one of the first international pediatric conferences and I was chairing that, and we had other people that came to that as well. That was nice.

S: So you've actually been an osteopath now for nearly 30 years, haven't you?

T: Almost 30 years, yes. 29.

S: How many of those did you work with John Wernham?

T: Well, I was trained under John Wernham. When I graduated straight away, one of the first things John was involved with in Belgium was establishing an Academy of Osteopathy. So there I was, green behind the ears, going straight from graduating with the body adjustment as my basis - and it still is my basis, the foundation for my work - and hey presto, there I was just outside Leuven, where I have a little clinic now, and training physiotherapists and other bodywork therapists in classical osteopathy. Yeah, one of my first subjects of discussion was osteopathic management of the cardiovascular system, and at the time I didn't realize that the university professor from Leuven was actually translating my material. That was a bit of a surprise after the presentation that I did.

S: Just before we went live, you were saying that there were some benefits to working in Belgium, because you said actually you can say what you like on your website, and-

T: At the moment, yeah, there seems to be ... I mean, effectively there's no regulations in terms of strict content, like we have here in the UK. But within certain components of that there is a general registration as such, which is a collaboration of osteopathic groups. But effectively there is no real regulation as such, as strict as it is here. So you can, for example, explain that you are a pediatric osteopath, or your work, having an interest in dealing with babies and treating babies, and you can do a huge list of things that you could say that you are treating.

S: Has anyone tested how that works in terms of your continued registration with the UK general council? Because if you're registered with them, they would say you have to adhere to-

T: Yeah. I mean, effectively what I do on my website is very simple. I have just direct links now to the GOC site, to the NCOR site, and to the actual GNRPO

site. So basically all the documentation that people need to find relating to what I do is formulated on those websites.

S: Yeah. GNRPO is?

T: It's the register. There's a continental equivalent of a register in Belgium, and they're the kind of organization that has brought all the other osteopathic registers that were pre two or three years ago together in that register. So they're still kind of formulating ... they've got structures and literature based on almost like the benchmark of what we have in the UK.

S: Before we move on, you heard me talk about chiropractors when we first started this evening. A lot of our members are chiropractors, and of course the institute of classical osteopathy teaches classical osteopathic technique, because it's classical osteopathic technique. But it is still just technique, isn't it? Which you've taught to other practitioners. So would you just like to illuminate what you mean by classical osteopathy? What is meant by it?

T: Well, it's based on the concepts and writings and ideas behind John Martin Littlejohn, but also relates to Andrew Taylor Still. So it's really a little bit kind of like authentic, you might say, or traditional, for want of a better word.

S: And for the chiropractors watching, Andrew Taylor Still is the founder of osteopathy.

T: Yeah. I mean, for the gentleman, John Wernham, who taught me, he had a very focused orientation on a classical approach to things. And for me, being maybe second or third general osteopath and being trained under him, I still have my very strong affiliations to John Wernham's ideas, the mechanical models behind that they developed, and also the body adjustment approach, the general body adjustment approach -

S: Well, again, I was gonna ask you to elaborate on that as well, because I think probably all chiropractors and most osteopaths think we do body adjustment. But it's a specific term that you're using -

T: Well, yeah. It's kind of like it's a rationale of treatment. I don't wanna put it under the terminology of a protocol, because protocols tend to kinda define things into simple boxes. But the body adjustment is kind of a holistic, integrative approach to treatment, so it really defines that concept of body unity. So we're looking at not just purely the structural aspect of things; we're looking at the neurophysiological aspect of things, but we have a kind of biomechanical model behind that. So we're looking at the way in which the spine and the curves and the development of the body changes over time, and we also respect the mechanisms behind that. But also, and most importantly, we look into the depth of neurophysiology associated with the body, too.

S: But surely, everything you've said so far could be said by any osteopath or chiropractor.

T: Of course, yes, and that is the argument of today. And I don't argue against that. For me, what I find interesting is I love to look back into the notes of Littlejohn, and look into other people like classical and other people involved with that, and other people that have done research in the past, and see very similar parallels. And I like to see that line of development in the concept. For example, this topic we're talking about tonight relates to that too. We have John Wernham with his ideas based on the biomechanics of the spine, which is being kind of documented and reviewed by Chris Campbell, and that is actually implemented within the body adjustment routine that we give. And like most of the documentation that you have with the other books that are now available, developing upon that theme or kind of with a similar basis to that idea, they all look at not just purely seeing that oscillatory process as a individual approach to technique. It's a component within other modalities as well.

S: So just, again, to clarify in my own mind, if not that of our viewers, you've mentioned the word routine a couple of times. And you don't wanna call it a protocol, but does that mean that with every patient you see there is a similarity in the way you address the treatment?

T: If you look at the process, or the routine, to the general eye you might perceive it as a specific type of protocol or routine. But when you look at the actual nature of the treatment, you are actually changing the parameters of the application of a lever on a fulcrum. The perception of the tissue that you're picking up through that dynamic of movement is different to each individual patient, so although the dynamic looks very similar, when you receive the treatment and you perceive the treatment it's completely different from person to person. But you stay within a parameter that is safe, and it provides basically the concept of providing a mechanical mechanism to induce some kind of neurophysiological response. So we go beyond that concept of just pushing bones and soft tissues around, and articulate structures. That concept goes beyond that. It goes into the idea of modifying the way in which tissues respond to certain types of parameters of loading, through to the dynamic of the way in which the body perceives that movement, too.

And that goes beyond just the concept of freeing up a tissue. You're looking at picking up very subtle changes in the way in which the sensory and afferent side of the nervous system picks that up, and according to the nature of the movement, the rhythm, then the body perceives it in a different way. And that's very interesting today because when we look at the fields of contemporary neuroscience and pain science, the nature of the way we treat has an influence on the dynamic of that response. And that becomes very fascinating to me because when we start looking at the field of how to

body perceives our external environment in relationship to the internal environment, that becomes a parameter that the body adjustment really kind of interfaces with. So that becomes interesting.

S: Obviously, because I'm an osteopath myself, I've spoken to quite a few people who are classical osteopathic practitioners in the past. Not all of them by any means, but on a number of occasions I've thought that their philosophy was a little bit wooly. What you've said sounds a lot more as though there was some research behind it, some evidence behind it, and that there is a science behind it as well.

T: Yeah, there is a science behind it.

S: It's not just because Andrew Taylor Still or Littlejohn said something, you do it.

T: No, no. No, I was very fortunate in 1995 to be involved with one of our Belgium students, and he was actually a physiotherapist working in a hospital in Lausanne. And one of the things that he did for his ... at the time it was a dissertation, was to look at the efficacy of our treatment approach using the body adjustment routine to look at the post-operative rehabilitation of patients that had semi-hemilaminectomies. So they had certain standardized outcome measures, for example McGill pain questionnaire, quality of life outcome parameters, also dynamic parameters. Also, that was kind of like a semi-longitudinal study as well, so that went throughout the year. He was familiar with those protocols, so then he implemented that within the research, and we actually did a comparative study. So we looked at how patients were looked at in term of just standardized physiotherapy rehabilitation, to thus him, and with my guidance in terms of the content of treatment, providing the body adjustment as that standard. So we had a standardized protocol as such that didn't change, so that provided standardization for the approach really.

S: Obviously we're not here to talk about the detail of research, but I want to dwell on that slightly, because you said you did a comparative study against physiotherapy.

T: Well, there was ... not against, but-

S: And of course one of my arguments is there is no such thing as osteopathy treatment or physiotherapy. It's what those practitioners to. So you presumably ... maybe there is a standard protocol for post-operative rehabilitation in physiotherapy in the hospitals you were looking at, but there will have been some specific techniques you were comparing to classical techniques.

T: Yes. I mean, we utilized the body adjustment routine, and the spinal oscillation was one aspect that we utilized. And what I want to bring across

today in the presentation is, when we look at the idea and the concept of spinal oscillation in terms of classical biomechanics, for want of a better expression, when you look at the nature of how the disc works ... if I can just maybe have a slide hooked up for me?

S: Yeah.

T: I'm gonna bring a little bit forward, and I just want everybody to just look into it and sort of find where it is. Here. There is a certain idea that when the spine moves, we have ... the movement of the spine, of course, works within that kind of tripod function of the disc, and that-

S: Yeah. So we're looking at the actual spine now, or the model spine, rather than the slide.

T: Yeah. Yeah, but it relates to the slide. So you have the component of movement happening within the body, of course, and the actual facets here. So that dynamic of oscillation worked within a certain arc parameter, and within the context of those arc parameters I just wanna bring up another diagram, if I may, because this illustrates it. You have certain regions of the spine which, when it's under load, have certain art parameters of movement. And within the cervical spine, for example, the actual line of results in arc movement, which is called oscillatory axis, is on this line. When you look at the ... according to the diagram, when you look at from the upper thoracic down to the thoracic lumbar, it runs on a kind of AP line - which then translates through to the tension in the coccyx itself.

And if you look in the actual anatomy, the functional anatomy that relates to that ... and that's what Littlejohn did when he looked at it. He looked at the morphology, he looked at the functional anatomy of the muscle groups. You get this transition of movement from one plane to another, and at certain points there's points of accumulation, of loading and forces. And within the disc structure itself, when you start to try to bring uniform movement through oscillation for the spine, it means that the whole vertebral group works in unity rather than a specific loading and compression effect providing the potential for change in disc functionality and effectively loading a disc and pre-cursing to maybe annular changes and of course fibrous changes, which again, perhaps create quite the dynamic of a potential disc herniation, for example.

S: Yeah. And I suppose I ought to reassure you, particularly if you're one of our new viewers, that ... I know it's difficult to take in the slides very quickly when Tim refers to something and then comes back to the model. But we do always post the presentations afterwards so you'll have the full access to the notes once we finish the presentation. But we'll move on. You're talking about Littlejohn doing this research; I mean, his research methods must have been quite limited in comparison to our own now.

T: I mean, he was looking at certain models and he was looking at certain-

S: So, entirely theoretical.

T: Yeah, a lot of it was theoretical. But at the same time, they had those kind of ideas that Fryette had come up with, and other people that were looking at at that time the dynamics of movement and loading and structural integrity. And that kind of intrinsically correlates to the idea of Ida Rolf, and her ideas on structural integration. Because Wernham and Ida Rolf had a dialogue between them; they knew that idea. And interesting, how I look at that dimension and how that extends into the idea of fascia, and the whole concept of that in terms of structural integration too. So there's, again a continual connection going on there. So there is this dynamic, and as soon as that dynamic starts getting a little bit chaotic in terms of the biomechanical factors of oscillation, things begin to potentially break down in terms of the functionality of the spine. That's the idea that we're looking at, in terms of simplistic biomechanics.

S: So you're in this evening to talk to us about spinal oscillation. What's that mean? Sounds obvious, but-

T: No, no. We're looking at the dynamic of the spine as it's moving as a uniform column, but at the same time we're looking at the way in which we can actually start to induce subtle changes within the dynamics of movement by applying some kind of leverage or a dynamic of fixation to change the potential interosseous dynamics of the articulations within the spine too. But it goes a little bit further than that. It also goes into the domain of the actual nature of the vascularization to the spinal cord, also the nature of the venous drainage to the spinal cord, and also the effects on the cerebral spinal fluid and the ventricular ligaments within the actual spinal column too. So it goes beyond that kind of simple mechanical concept into almost that kind of newer physiological idea too.

S: So where are we going? Presumably you're arguing that spinal oscillation will improve vascular drainage.

T: Yeah, it has the potential. Because any kind of psychic pumping movement ... and this is where the idea of Zachary Comeaux and also Eyal Lederman talk about these dynamics, or not just purely movement qualities, but going beyond that whole mechanical field into that physiological field.

S: Well, Eyal Lederman's quite busy in teaching and talking about harmonic technique, isn't he?

T: Yeah.

S: Is that more or less what you do?

T: Yeah. I mean, effectively, if you look at the timeline, you have Littlejohn's concepts, you had Wernham's concepts, all based on that concept of spinal oscillation. And then we have Zachary Comeaux developing upon that concept too, and then Eyal Lederman's coming along and talking about that in terms of movement too. So these concepts all have fairly similar ... if you actually look at the books and the literature, they have very similar kind of ideas, and some aspects of neuroscience and neurophysiology being explored in more depth. And this is nice because it kind of for me ... when I look into the literature now I can go back in time and say, "Ah, this is how this has been endorsed, or has been given some degree of evidence base behind what we're doing."

S: Right. So what is the theory, then? Movement is good.

T: The main idea, the main movement is good. The main concept for us in the classical idea is that we are kind of trying to establish the integrity of the spine in terms of the functionality of the interosseous articulations. But most importantly, the actual resultant loading on those facets as they move along those particular planes ... and as soon as you've got a potential compromise on that, whatever that may be in terms of the dynamic of movement or the loading or the actual resultant forces going through the spine, it starts to create torsion and distortion. So what I'd like to do, if I may, is go back to this little diagram.

S: Sure.

T: Not diagram, but this actual film. Because quite often when you think about potential distortion and how movement and harmonics work ... when they work well it goes well, and the spine moves freely. Interosseous ligaments are working freely, disc function is good, vascularization of the cord is good, venous decongestion of the cord is good. And the functionality of the actual dural tube and the CSF circulation is good. But as soon as there's a compromise in movement, there's a potential for changes. So this film that you'll see coming up now looks at the ... you might have to click it again. It looks at the way in which structures deform as a consequence of unnecessary oscillatory loading on a structure, and-

S: But this is bring done by wind, isn't it, in this case?

T: Yeah.

S: You say unnecessary loading, sure, but isn't there more to it? I just seem to remember talking to my physics instructor years ago, and Eyal Lederman did a lot of this in... So actually it's a rhythm loading at the frequency which is in synchrony with the harmonic frequency.

T: Yeah. The resonance, yeah. And what happens is, as you probably saw this when we were looking at the film, you'll see that gentleman that came out of

that scenario had to stay running along that mid-line. So that's the still point of oscillation, and this is what we're trying to do. We're trying to maintain or restore that still point dynamic within the spine, so there's not excessive loading or torsion patterns going through the spine. So when we're looking at our treatment, we are looking at the nature of the dynamics of the spine in terms of global movement, and then hey presto, this is what effectively can happen. I know it's as a consequence of wind, but that's an extrinsic force.

S: Yeah. Exactly, yes. Yeah.

T: Our own body movements, gravity, et cetera is an extrinsic force, but it has an influence over time.

S: One of the applications I remember Eyal Lederman teaching is of course that if you use harmonic technique effectively it reduces the strain on your own body, because you're using that resonant frequency to develop the movement that you want to.

T: Yeah. And that's the nice thing about the body adjustment, too, is that when you're doing the body adjustment routine you're going through a routine of movement, and you're perceiving the tissue response and the restrictions through that dynamic. And you're using that long lever, which is very refined, to that fulcrum point and to those tissue fields within the context of your hand on contact to actually perceive the movement and the nature of that. And at that time you can assess, ease off, and then start to actually influence the dynamic of a barrier or a restriction within the context of not just purely a physical effect, but also dealing with those very refined proprioceptive dynamics in the tissue structure.

S: Do you find it's hard to find the correct frequency to perform your treatments at, or the correct place that… falls?

T: Every patient has their own inherent rhythm, as we might say, and to begin with, yes. Day one, when you're trying it, you're all over the place. Well, eventually you get that skill set where you're gonna start to apply levers, and the nature of the fulcrum in relationship to the nature of the lever can be modified, and that can become very precise as well. And that creates the need ... and it doesn't necessitate the need to provide a lot of dynamic movement, and that's what happens. When you look at the comparison to the GOT, which is basically a loosening mechanism to the GBA, there isn't that gross dynamic of movement. It's refined and-

S: You might have to explain the GOT and the GBA to our audience.

T: Yeah. The GOT is the general osteopathic technique, which is very much based on freeing limbs throughout a protocol which is very similar to the general body adjustment. But we changed it to the BA because we're looking at not just purely the mechanical and movement range. We're looking at the

context of the newer physiological responses that we're getting, and we're dealing with that in terms of not just purely moving a structure, but the influence of changing the parameters of spinal movement and freedom in relationship to thoracic cavity dynamics, to do with fluid dynamics as well. So that has an extension from this oscillatory mechanism.

S: Is this a concept which is unique to osteopathy, or do other disciplines employ a similar approach?

T: I think there's overlaps. I mean, when you look at for example in the roll structural integration approach, and then you have the fascial structures that people are involved with now. There's a lot of similarities, and the interfacing of tissues are similar. But sometimes there's a lot of dissimilarities too.

S: Yeah. I mean, people will know I'm very keen to ... what's the word? To make our presentations relevant to everyone who's watching. And it does include some physiotherapists as well as chiropractors. And I hate, by talking about general osteopathic technique or classical osteopathic technique to imply that the chiropractors don't know anything about stuff, which of course ... I mean...

T: Oh, no, no. I mean, the thing is, the interesting dynamic about today's research is that it begins to overlap all these fields. And this, for me, it's fascinating because when I'm working on a patient and I'm looking at the responses that I'm getting, I'm always thinking, "Okay, I'm getting that response." And I've got a rough idea, or I've got a fairly comprehensive idea what that response is. But where is that in terms of other mechanisms? What is being ... so this whole idea nowadays relating to the ... fascia has become a very interesting field because they're discovering a lot of new ideas behind that. But at the same time, now it's gone back and they're saying, "Well, how do we define fascia?" What is a fascial tissue? Does it start at the bone or is it periosteum? Is it what? Is it a continuum of a web? So again, it's interesting.

S: So where then is spinal oscillation applicable? What sort of problems would you address with it? I mean, we all hate to say that ... we don't wanna treat conditions, we're treating a body...

T: No, no. I mean, the thing is, there's never time in my treatment that I never use it, because my benchmark for me is the body adjustment, because that's the way I was taught and that's the way I approach things. So within the contents of my work, even when I'm working with young babies, I will use a degree of gentle mobilization and oscillation if needed. A lot of the time I'm using gentle leverages with a little bit of oscillation as well, because the body movement and the perception of gentle movement is something that the body perceives and takes in very well. Erratic movement isn't perceived so well, it's perceived as a challenge. So for example, if I can just do this on your

knee, for example. If I was doing that movement, that's more calming to you. But if I start doing this, it's like, "Oh, you're waking me up."

And your higher senses in your brain are perceiving that, your amygdala for example is perceiving that as a potential threat perhaps, or not. So this is why when we're working with tissues we wanna work in a calm, soft way, so we're using diffuse activity to those tissue fields without inducing any type of potential irritation, or being perceived by the body as a threat. And this is where it becomes very interesting when you look at the nature of touch, how that is perceived by the patient and how that can be perceived in the context of treatment as being of value to them or not. Does the patient come from a treatment thinking, "I'm relaxed and I've benefited from that"? Or have they been over-treated, and they come out thinking, "Oh, I feel nauseous. Oh, what happened?" And they put that down to, "Oh, that's the treatment reaction." Well, not necessarily always the way.

S: Let me try to be a bit more specific in this. A mother comes to your clinic and shoves her baby into your arms and says he's got colic. And I don't wanna get into the definitions of colic; you said that it's very seldom when you wouldn't use this treatment. Would you be looking to apply spinal oscillation to a specific area of the spine for a condition, if I can call it that, such as colic? Or would you just be looking for the restriction and saying, "Well, it's-"

T: I would be always applying this concept of a long lever on a fulcrum. That is the basis behind my work. Now, the nature of that oscillation might be a situation where I have the little baby on my knee, I'm working underneath the diaphragm and I'm providing a little bit of gentle movement. Now that's a calming, soothing movement for a baby, and at the same time I might provide a little bit of paravertebral inhibition around the spine, maybe in the mid-thoracic-

S: What would make you decide to do that or not?

T: The sensation of restriction. So I know nowadays there's a lot of criticism, or potential kind of curiosity of whether assessment of movement is a valid scenario nowadays. But for a baby that's just been born, that there's no osseous structures really that we're working with - very flexible, dynamic structure - we're kind of subtly feeling and perceiving those tissues' responses to that movement. As soon as you start to provide some type of movement there will be some motoric response, so the tissue field will pick it up. Sometimes you might actually provide a little bit of infrasternal relaxation and releasing around that gastric area that's been under pressure as a consequence of quite a dynamic. Birth, for example.

So all these parameters of colic and things like that can quite often be attributed to changes as a consequence of delivery in the relationship with the infrasternal area. For example, an interesting aspect about babies is

they've got a ... we all have this primary C curve that's embryonic in that region, and sometimes that gets compressed. There's potential for that to become sensitive. So sometimes babies don't like to lie on their back, because there's a slight sensation of sensitivity, so they struggle. You put them on their side, or you put them on the shoulder and they're completely calm. So that whole idea of perception of sensitivity can be there from the beginning as a consequence...

S: I suppose the burning question for anyone who treats babies is, well, what's the strength of the evidence for? And who's doing the research at the moment?

T: Well, that's it. I mean, for us it's very interesting to see if there are pediatric centers that are busy with that. I could imagine the OCC may be busy with that because they have the opportunity to work in hospital environments. You might look at certain parameters and markers that you can find in for example the urine and things like that, that indicate various aspects of stress. Cortical changes, for example. So what is the values of that?

S: But at the moment we don't have anything that we can rely on to say to the advertising standards agency, "Here's why we're doing what we're doing."

T: No, unless of course you kind of have a scenario where you have a whole lot of midwives that can say, "Okay, this is a particular presentation. This is particular type of delivery that they had. These are the presenting symptoms that they're having." This is a standardized intervention that was done, and this is the outcome according to what value you can obtain from the baby. You can't interview them, so you're looking at physiological markers that you can use. Yeah, it's early days. Maybe there's someone at this moment doing that.

S: Then we heard of the Institute of Osteopathy's convention last weekend that there is some research going on into pediatric treatment, and I think Don Combs is leading that. I can't for the life of me remember what the actual topic of the research was, but the fact that there's some going on will be reassurance to a lot of people.

T: I think so. The end of the day, there are enough parameters to use in terms of certain standardized outcome measures. If you can start bringing those and implementing those into some kind of standardized tuned approach, and you got values that you can assess, then that's the beginning. For us in 1995, it was a case of what can we work with within the context of osteopathy? Because there was nothing published. The document that we produced couldn't be published in the Spine. At the time, there were no other journals, so it was like my colleague was there in 1995, done the research, got some good outcomes, but couldn't publish it.

He's got it, actually if you look at the researchgate, it's there. Pascal Bulo is now doing very interesting work in actually the functionality of the vagal nerve and those aspects of inflammatory rediation for the vagal nerve, because that's another aspect of our work which is fascinating.

S: This might be a digression. I don't know. What research ware you involved in at the moment?

T: I'm in the process hopefully next year, I have a specific interest in multiple sclerosis. Two years ago, I was kindly invited to do a presentation on that. It was in an environment where we were talking all about the autonomic nervous system and trauma. I had basically-

S: Who was this for?

T: This was one of the German schools, Tolstein Liam's school. It was a convention like the IO convention, and Christin Fostin, who I know kindly invited me indirectly through the organization there, or recommended it would be nice for me to turn up. Yeah, I've been looking at working with MS patients and applying this approach, the body adjustment, but I didn't actually present it as a body adjustment. I presented it as a multidisciplinary approach or multisystems approach. I looked at working with all the systems that are typically affected or influenced by this condition, for want of a better expression, and looked at those parameters that we can start addressing, specifically the GIT aspect of things, rhetoric aspect of things.

Also looking at various parameters of cognitive activity. I'm very interested in potentially neuroplasticity and whether we can use QEEG analysis to look at the way in which the brain changes as a consequence of treatment.

S: Did you actually use HVTs in the top?

T: When I'm working with the few patients I'm seeing at the moment, I use very gentle HVT. I'm working with… dysfunction, problems with a hematory system or semiparesis. We're having this typical gate problems. There is dysfunction, there is pain. Yes, I do, but within the context of the patient and within the context of the tissues that I'm working with. I don't force. If I know that there is a tissue field, for want of a better expression, that is not going to tolerate HVT or anything like that, I won't do it.

I would prefer to use a screening approach. Once in a while I will. If that patient's constitution can actually deal with it, because with these conditions you treat for a very short time and have to deal with the consequences of ... Overtreatment is one thing you have to really be really careful of with MS patients so you don't start exasperate conditions rather than actually start to help.

S: Right. What's the goal of the study? The outcome measure?

T: The goal of the study, the outcome ... Well, I got so many outcome parameters, but within the context of MS, we are always looking at that scenario of relapsing remitting episodes. The timeline between relapse and remitting changes over time. What I would like to be doing, and I will begin, there's some parameters that are looking that way, is to try and to maintain that timeline between relapsing and remitting, or actually reduce the potential for it to increase. As soon as they go beyond two or so relapsing, remitting episodes within a year, they go into a different strategy of management.

It becomes very, very strong management with a lot of medicines that relate to palliative care. As a consequence of that, that changes the parameters of the patient. They become very dependent upon medicines after a while, and then the whole conditions begins to accelerate downwards, unfortunately.

S: You think because of the intervention?

T: I think it's because at the end of the day, you have that balance between the effectiveness of the medicines palliating the symptoms, but at the same time as a consequence of the need for using interferon-based medicines, for example, you have the neurotoxic effects or the equivalent of neurotoxic effects accumulating as a consequence of that. You're trying to aleve the other effects, but the outcome is eventually that the patient is dependent on so many other meds that the body's constitution just can't deal with that over time, which is rather unfortunately.

What I'm trying to do is turn that around and look and see if we can actually get motivational-based exercise that is being monitored on a day-to-day basis. I'm using BLE sensors to pick up data onto a server, and that gives me feedback on their exercises. They are actually developing their own exercise routines. Every time that they're tired or if they think they can still keep moderate exercise, and if they're feeling better, they can go into a next level of exercise. It's not based on progressive exercise and incremented exercise. It's based on ability and motivational ability.

I've got these people actually busy with actually trying to take that label of MS away, changing the quality of their life parameters, and actually being involved with each other, dynamically communicating and saying even to the extent of having the Bristol stool chart being used for their constipation values, and actually then laughing over a cup of tea saying, "Hey, I'm number one today because my values are better than you." As a joke. I'm turning that around. They don't even perceive their constipation as an issue for them. They're focused on diet, movement, exercise to actually encourage themselves to get out of this scenario.

S: I have a patient who would quite like to meet you, because I don't see him very often because I think he oscillates between ... Sorry.

T: Yeah, that's good.

S: Oscillates between different practitioners and between different interventions which have just hit the news and so on, but he refuses to accept the label of MS and says, "I don't accept this label." Even though his gait is now severely effected and he suffering some severe consequences of whatever it is that's going on. Yeah. Unfortunately he's not in Belgium.

T: No, no. At the moment, I've got a small group. I've got a semi-pilot structure to it. They've been very cooperative, and they're helping with being able to get certain parameters that I can evaluate and see, "Can I use that evaluation of that parameter evaluation or not?" They're part of it, and that changes that dynamic. It takes the label away and gives the quality of life value, and that's what we're all about.

S: I've had a question from somebody who's not willing to give their name, but they've asked whether you think that cranial movements in CSF should be incorporated, or maybe they are incorporated into your evaluation?

T: They are, they are. Quite so.

S: Would you say you are a cranial practitioner?

T: Let's just say that I apply cranial approaches to my treatment, yeah, because if you look at John Williams' work, we talk about the craniofacial modalities or technique. One for example that comes to mind dealing with that is the whole consequence recently, it's really fascinating when you look at the consequence of neurotoxicity, especially in the brain, and the whole discovery of the lymphatic system. That's very interesting that we have this whole mechanism now that relates to the ability to actually get rid of circulatory amyloid and things like that that are in the brain creating specific and inflammatory responses in the brain by the dynamic of the lymphatic system.

Within the consequence of our treatment, we've been working with those protocols or those approaches for quite some time. When I look at the American schools, and they produce these videos on what they've been doing, and the protocols and research has gone behind that, the lymphatic system. I love it because it really endorses what we've been doing in terms of not just purely working with the cranial dynamics, that's very valuable, but with the craniofacial and the actual lymphatic mechanisms behind that, too. What Little John didn't do, he didn't break things into various compartments.

He looked at the whole picture, and when Wernum looked at that, too. We've got certain methods like vertex inhibition, things like that that was use, suboccipital inhibition, which are very similar to CV4 or frontal lifts or paretal lifts, but we don't actually say that that's what we're doing. There are a lot of similarities. One of the things I give as a lecture with the ICO is a little

bit of a comparison between either idea of Sutherland, Apanja, Magoon, and all the other models in relationship to the classical concept.

There's a lot of similarities there. If you look on the institution website, there's actually a video of someone, I can't remember who her name is, I see talking about cranial technique in the osteopathic field. It's there. It's not as if we're neglecting it. It's integral to our work, yeah.

S: I've actually come over some criticism. Again, this is another person who won't identify themselves, but last time we broadcast, it was our first time in the studio, and we actually had wine in the studio to celebrate. I'm being criticized for not having any Malo this week, but whoever it is says that he's got gin, or she's got gin. They have a question, as well. They want to know what you mean by tissue not tolerating HVT. What would you expect the problems to be afterwards? Whoever it is says they appreciate it sounds like a challenge. They don't mean it to be, but they can't think of a different way to word the question.

T: Okay. For example, there may be two scenarios. There may be a scenario where for example the condition within a particular osteo's field, for want of a better expression, has become chronic, very fibrotic, very resistant to mobilization. You might be providing it too much forced into that tissue field, and that might create microvascular injury, for example. There's a lot of interest at the moment on suvicle adjustments, and how that can again potentially potentiate vascular injury, things like that.

Also, there's a time sometimes when maybe the actual joint itself might be in an inflammatory state that doesn't tolerate HVT at that particular time. You might use gentle ... That's what we'd like to do. We'd like to use longer lever fulcrum mechanisms to provide degree of freedom, tissue freedom, for want of a better phrase, or osteous freedom without the need to actually provide a strong application of force or a vector of force directly to the tissues themselves. There might be for example the case where there might be some kind of degenerative underlying scenario in the actual osseostructures of the bone.

You might be able to do your screening, do your red flags to identify that, but nine times out of ten, you might not even pick that out. For me, that's the nice thing about when I'm working with it. I work within the parameters that I find in terms of the tissue. Compliance, the ability for the tissues to respond to the dynamics of the levers that I'm using.

S: We're getting some questions in here, too, about how you actually do this technique. One I've got here is how do you work on the lymphatics? Again, I don't know who it is that asked the question. The person says they're quite new to the profession, by which I assume they mean osteopathy. They've

been taught very gentle techniques, but some of her colleagues or his colleagues use more harmonic techniques.

T: I think maybe it would be best for us to show some ideas-

S: Yeah, certain area, and at least people can go in, maybe some techniques that people can-

T: Yeah, how are we for time?

S: We have plenty of time.

T: We have plenty of time. That's good.

S: I'm keeping an eye on it.

T: Going back to the idea of the lymphatics, within the context of the body adjustment, and within the context of oscillatory harmonic technique, I must emphasize that the body adjustment is a routine that actually integrates this oscillatory technique. We don't do it ever just on its own. The approach is designed to apply a mechanism where we're providing supine, prone aspects of treatment that we're dealing with, providing a peripheral influence onto the central influence of the body. Leg rotations, for example. Movements or conduction, for example, in a certain pattern, a certain way.

A lot of the time if you look up the term CCP, common compensatory pattern, you look at zinc's patterns, as well, you get that tie-in, because we have this universal benchmark idea that there may be torsional patterns in the body, and we're beginning to try and address those torsional patterns in the body, but like the zinc concept, too, and those things that have to do with facial dynamics. We will be specifically looking at how the base of the pelvis, because we got this foundation that is influencing the structure above, for want of a better term.

I don't like the term structure osteopathy, because we always associate it with the fact that we're just working with bones and actually just providing HVTs. It's far more than that. We were looking at the nature of the presentation maybe of the anomaly in relation to left to right, sacral relationships in terms of the angles, all these various components to it. What is happening at that baseline of the pelvis in relation to the lumbar sacral junction, and how that translates in compensatory dynamics above? Including into the basiocciput and really into the actual cranial and subcranial, too, so that doesn't continue from there.

Going back to the lymph?

S: Yeah.

T: When I'm working with the lymphatic ideas, I know for example that I've got the relationship of the… then the right and left thoracic ducts, and the diaphragm. The main concern for me is to make sure that we have diaphragmatic freedom, so we get excursion in the diaphragm, which is providing that natural lymphatic pump, but at the same time, we're looking at what is happening in relationship to the other lymphatic structure within the viscera themselves? Also, how are we actually encouraging that diaphragm to release that?

Within the context of treatment, quite often the patient is supine, but we're eventually here sometimes doing them over prone. I'm specifically interested in wanted happening in that thoracolumbar region in terms of those floating ribs, in terms of insertions in relationship to the soas, for example, that can have a profound effect on the floating ribs, as well. Also, we might provide gentle compression or decompression AP, springing or side-bending rotation, which I show of that.

In relationship to those floating ribs, the diaphragm insertions, too. We will not, at the same time, we will also include happening in the supraclavicular areas, and also the drainage in relation to the face and the neck. This is why we, with the body adjustment, we go through that systematic protocol to deal with all of these associated structures, not just, "Here is the syternacyli. I'm going to pump around the diaphragm." I want to know what's happening with the whole relationship of lymphatic. Lymphatic lines to the venous.

Venous system is a mechanism through which the lymphatics have a passive drainage mechanism. Looking back, you look at Little John's notes on lymphatic, the first thing he talks about is heart force. Is the pump of the heart creating enough arterial functionality to encourage that hydrostatic difference between venous and arterial to encourage the venous return to be optimized, sucking in the lymphatics, for want of a better term? That's the whole idea behind it. We're not just purely working one system. We're looking at the whole constitution, the whole functional.

S: Do you have a look at what…?

T: Yeah, let's have a look. Yes.

S: Let's move over and meet our model for the evening.

T: Yes, we will. Okay.

S: Kate has come in to help us out with this. Kate is a osteo student, ortheo student, had her second child in November, which is almost a year ago now. Kate, would you want?

T: Are you going to be all right?

S: Welcome to the show.

K: Thank you.

S: Thanks.

T: Are you going to be all right to lie on the couch, as it is?

S: Yep.

T: First of all, let me just have a look at that, if you like to lie on the couch on your back for me.

S: My back?

T: On your front for me, if you want. I'm going to focus on oscillation, because that's the theme of today, if that's okay.

S: Yes, please.

T: What I want to talk to you about is also the fact that we have this profile of the spine, and what we want to try and do is try to optimize the way in which these axial, I'm going to describe the spine. I'll be off camera for just a second.

S: We'll just talk amongst ourselves.

T: Yeah, that's fine. No, no, no, I can still talk to you. We're looking at specifically looking at the profile of the spine, because what we don't want to have is a situation where the actual patient is lying the position where maybe there's an extension group in the paravertebral muscles are holding themselves in fixation there, or we have an area where there's too much lordosis, for example, too. What we're trying to do is-

S: How do you know what's too much, though? Everyone's individual-

T: It is. Yeah, the terminology I'm using is a bit simplistic. We want to try and provide in each situation where that joint on each specific level is in neutral.

S: We've just been picked up for something. I know you've got answers for this, because I've got no face hold. Specifically somebody did not want a face holder, and it's good that you ...

T: This is one of the interesting questions that come up all the time. The reason why we don't use a face hold is because when I'm dealing with oscillation, and we're dealing with our model behind it, quite often within the treatment protocol, we worked the vital region already. We've maybe done specific work with that in terms of adjustments, too, or HVTs. What we're trying to do

here is when we're providing oscillation, the movement of oscillation is a nice rhythmic oscillation approach. The trouble is if I do that, if I take the foot out there, there, comes out.

I put her face just in there. What tends to happen is that oscillation comes right up into the basiocciput and begins to influence the vestibular pari just a little bit. The fact that there's a little bit of a nodding movement.

S: Doesn't that unavoidable torsion in the spine, if you've got your patient's head turned one way or the other, affect what you're doing?

T: Yeah, it does. The thing is that when I'm not working with the oscillation component, within the context of the treatment, we've started to address these mechanical problems in the neck. Later on we might go back to the them in the context of the treatment, too, when the patient is sitting, for example. We can provide the harmonic oscillatory movements for that. The main issue is here is that when we're looking into the dynamic of oscillation, we don't want too much movement to go into this basiocciput because we've got a lot of refined areas there.

They've got the superior cervical ganglion, for example. We got the ganglion nervonal around that suboccipital region that are maybe going to pick up that dynamic of movement and induce some kind of unnecessary overload, what you might say for want of expression, of a sensory input. That quite often create, not in all cases, a little bit of nausea and a little bit of discomfort. Another scenario is also when you've got your head down there, quite often you can't see what is happening with the patient as you're oscillating. That face, turning the head this way ...

That neck, this person got a neck problem there. I wouldn't necessarily modify that. What I can do is if I take the thing out again, lift your head up, I can still provide oscillation. If the person's got a neck problem, I just provide a little bit of this positioning here of the head with the the cushion. Turn your head that way just a little bit. Then usually within that region, that is enough to provide a little bit of balance.

S: You coming through on that, Kate?

K: Yeah.

T: What I do to compensate that, we'd probably get another cushion. I know it sounds crazy. If you lift yourself up a second again. Then we put that there. Then I can then provide oscillation with the head towards me, and I can oscillate, and the neck is now add to any strength. This is what we do effectively, is we're working with an application of induction movement, and this always stays here. This is providing a uniform induction of movement, an oscillatory movement. This varies according to the nature of the pelvis, remember. We've got a flat pelvis, a broad pelvis.

I'm using this vector to induce a rhythmic movement into that lumbar sacral junction so that that movement becomes translatory oscillatory on axis. What I'm doing first of all is just feeling how those paraverta muscles are working in terms of their response to that oscillation movement.

S: Isn't the effect going to be an awful lot less up here than it is down there? Couldn't you get a better sensation if you actually applied your force higher up?

T: You could do, but the nature is that we want to provide a uniform, harmonic movement. What we have to think about also when quite often we're dealing with this is the fact that within that dorsal to dorsal lumbar area here, we've got that sympathetic chain. This is what we're interfacing with, as well. A lot of the time if you look at the territory, I've got a picture of that I'll show you later, the territory of the dorsal root, is coming from here. The sensory side comes from this part of the skull all the way down to here. If we're engaging that DRG, that dorsal root ganglion, the relationship with that to the segment.

I'll show you a diagram of that. This is when it comes into the dynamic of assessing the vertebra. What we're doing and looking at key points in the spine that we relate to is almost augmenters of movement, and the transition points that we look at in terms of observations of changes in the morphology and the function of the joints are around the cervicodorsal. Also in relationship to the fifth lumbar, and some respects to the dorsal nine vertebra, too. Not 11 and 12. The mechanics of Little Johns talks about the dorsal nine as having multi functions.

It act as a supportive function in terms of the transition of a curve activity, like a keystone in a bridge, for example, but it's also dynamic, as well. It's actually a pivotal point, but it's also an oscillatory point. Like a governing system in an engine, these various points here are actually the points that we relate to in terms of the dynamics of the vertebra above and below. When you look into Little John's notes and material that we talk about, we talk about individual segmental movement, but also group movement. What we're looking for is a change in a dynamic of that oscillatory movement coming under our fingers.

Quite often that is like, for example, you're tying a knot in a piece of rope. If you start moving a rope around, and you feel around the knot, you'll feel that resistance in that knot. It's an analogy, but that's as close as we can get to.

S: You're palpating on the opposite side of the spinal.

T: I'm palpating both sides.

S: Are you? Okay.

T: With both fingers, digital, so I can compare and contrast for any contracture or expression of tissue change.

S: What are you finding in Kate?

T: Okay. Here we've got a gentle lateral curve coming through. We got a side bending rotation to the left a little bit, indicating the spine is processed profile on the body profile, so that'll be the opposite. What I'm finding here is around the dorsal nine, this area here, there's quite a lot of resistance to movement. That area is under a degree of compression or compromised movement to some degree, want of a better terminology. Also as I'm going through, I'm also trying to feel what's happening in terms of just the freedom of movement segment to segment.

For me, I want to see how the body is over time adapted to various mechanical movements that are happening. We relate always to this idea that we have this primary curve in the body that evolves over time. We have a specific interest in what's happening between the junction of the fourth and fifth dorsal down to L1 and 2, because that's the region of the body, which is a primary curve. Then cervical and lumber spine development is adaptive. It's adaptive dynamic, depending on whether we're calling whatever.

That is particular of interest. Is that spine fixed? Is it working quite actively as a spring mechanism, or is there a scenario where maybe that primary curve over time has adapted and has become fragmented, or the dynamic of that movement is changing? Also at the same time, when you look at literature on the nature of symatic dysfunction or the lesion, as it used to be called, there also is what I'll call neurotrophic changes that can occur. Quite often when there's been an acute onset of a tissue injury or something, you get this certain expression of hyperemia irritability.

Over time, if that tissue field becomes fibrotic and rigid, then the nature of the actual tissue above it is also influenced, so that relates a little bit to the dynamics of superficial tissues.

S: There's a question come in about this. Again, not a single person has actually identified themselves so far. I might stop asking you questions, they didn't tell me their names. They fear they might also sound a bit confrontational.

T: I don't mind. I don't mind at all.

S: They want to know how this differs from just gentle articulation, rhythmic, exploratory, or focused, as they put in here.

T: Yeah, that's not different at all. You're looking at that. The thing is that we're working with a dynamic of assessing and then providing a treatment in situ. For example here, for example, a little bit of a side bending curve here. I will

then start to think, "Okay, I want to try to have gentle influence on there." We can either go into the tissue restriction, and then come out. This in analogy to, if you want to get a screw out of a wall. If you try to unscrew the screw that's in a wall, it's been in a piece of wood for a while, you have to have a lot of load on it.

You torsion it, and there's a potential of injury to that entry, damage to the screw or the screw driver. If you screw into the wood first and the come out, it comes out easily. That's what happens with what we're doing with our dynamic of movement here. There might be a little bit of restriction here, so I can go into that restriction one side. If you notice I'm changing the dynamic of my induction here, I'm providing a little bit of a kind of movement to that.

S: Yes.

T: And then I'm going further onto the other side. So what effect we have-

S: You changed the frequency.

T: Yeah, and also because in order to get to that point you then change the dynamic of the oscillation a little bit, the frequency.

S: How does this feel to you Kate? Is this comfortable?

K: Yes it is. It's fascinating feeling where he is. He's-

T: Spot on.

K: Spot on.

T: So yeah, and a lot of people say, "Well how come that is?" Because you're looking at, not just engaging the idea of palpatory tissue expression, we're looking at dynamic palpatory tissue expression. And that movement acts as another parameter to your assessment. What we often do is we get the patient like this, and then we're gonna like, twisting, twisting, twisting, twisting, twisting, but that's only one parameter. And quite often that for the patient that's in their sensitive environment, you know in pain, it's too much for them to take on. And quite often you don't see them. So, that's quite often why we have the face hole towards this as well. Cause we wanna see what's happening in that facial expression. Now if you look at her face now, it's becoming a little bit pink. And that's because I've been working with the spine and that's created that avascularization effect on the surface of the skin. But at the same time, that's had an influence on the upper thoracic innovation through the vascular innovation to the face.

So this has become a physiological response to a mechanical influence.

S: I've been trying to find a convenient opportunity-

T: Yeah

S: To put in this question, which is coming from somebody whose given me their name.

T: Yeah.

S: You're gonna get asked this one definitely. Sarah. Sarah asked about it, and I'm still a bit confused myself, is confused as to what's the problem with the face hole or why is that causing a problem with your technique or your examination?

T: Well, the thing-

S: I know you explained it, but-

T: The thing is that what we're trying to do- when we've been through the body, you go through the routine and the body adjustment, your supine work is hip, upper girdle, hip, upper girdle. And then you're working, also, in relationship to the spine as well. Teasing and easing various profiles and movement. And then you become more specific. You're attending to the neck, so any restrictions that you find you deal with straight away with the new adjustments. That means that the neck is ready to be freed. So, we've freed up the neck, you don't to provide further irritation. So, for example, if I start doing this to you after I've just released your neck, that's gonna potentiate further potential problems for the patient. Especially, for example, if they've got-

S: So you've already done your general body adjustment before you start doing this?

T: This is part of the… routine. I've done the supine part of it, I've released the neck, then we put the patient prone and we actually start-

S: I suspect Sarah is still gonna say, "Well why is it a problem if you're using a face hole?" Given that you've now had to apply some extra cushions to take the strain off her neck. What is it that's causing a problem by simply having a-

T: If you're putting the head in this position, what tends to happen is- as we start to work with freeing up the tissues and working with that area, that is the final common pathway for the movement to go through. And then you've got a fixed structure. You've got the OAA complex, which is got a lot of very sensitive tissues, very sensitive nerves. And you've got that sensory-

S: Why does this all change because the head is rotated?

T: Sorry?

S: Well, I mean, if you've got the head through the face hole, most of us would think, "Well that's more comfortable for the patient than turning their head sideways." But either way we've still got that structure and the head is still fixed in this position-

T: But in this position now, the dynamic of the oscillation comes to this point and it doesn't translate too far apart. That's the main issue with it. And if you look at the biomechanical model behind this, the idea behind what's going on, the D2 to 4 is a very critical region of the spine because anatomically, our neck fixates there. But in terms of weight bearing of the head, D2 to 4 is responsible for that. So quite often, we've released the neck and the head, we don't want to do excessive, over-treatment. We don't want to over-facilitate the scenario going on. So this is the oscillation movements that we can do.

And quite frequently we are looking at addressing potential dynamic for the vertebrae to side bend, rotate, stay fixed with particular adaptive tissue over time, okay? And we try to provide tease and ease of the these androgenous structures, but at the same time as we are beginning to do that, we're changing the actual deeper structures within the cord itself. And I'll show you a picture of that too, if we can, of the avascularization of the cord is very important too. Because if we don't get good avascularization of the cord, you've got these scenarios, these nasty conditions, where there's influx of the cords creating all these various effects. So, effectively, we're trying to optimize the avascularization of the cord. Also, the decongestive side of things, and also through that dynamic, the freedom of the ventricular structures that are providing that support within that cord too.

S: How about this one from Robin? It says, "Yep, this is what I use," presumably your oscillation technique, "How do you feel about applying a focused pause over the tension point to disrupt the restriction?" He says he's, "been getting great success and often initiating a spontaneous release type event."

T: You can provide various dynamics within this area. And what I will emphasize, also, is quite often we have been also working with a dynamic of the pelvis. We've also quite often used the leverage of the leg to go into those areas. So we can actually start addressing points of fixation. We can do whatever we want. And quite often you might even apply for example with the thin emininences just a gentle bit of ventral pressure to take out that extension or reflexion group. Or you can, at some stage, quite often we might just provide a little bit of gentle interim compression like this. Also, for example, this hand is very critical because we can provide an extension and flexion kind of rotation while I'm bending. As soon as we start to introduce a vector, at that point, it provides potential for side bending rotation if you believe in that concept of side bending rotation, coupling mechanisms, et cetera.

S: Interesting that you would say that because someone's asked a question about that. First of all, Sam said, "Do you always do your oscillation through the pelvis?" Which you did answer earlier on. But somebody has also said, "Do you diagnose joints by positional restrictions? Rotated right flex-"

T: I tend to relate to that as a point of reference, but to be profluent with you, I'm not a person that goes along and individually works into the components. Because a lot of the time, we're working with groups of vertebrae. And I'm looking for specific areas that might be representatives of a specific segmental dysfunction. But at the end of the day, you can quite often see the expression of the movement, the dynamic, the curve of the relationship to the vertebrae above and below it. And if you want to look into the dynamics of, is it a first degree or a second degree lesion, which that terminology is not used so much nowadays, there can be traumatic scenarios where the vertebrae are lifted and there can be some function of unloading on the joints. Quite a profound representation of dysfunction if you want.

So what I want to do, if I may continue, is just show this can vary. And we can actually provide, if we need to, a degree of traction through that area or compression. So we, again, can go back to that analogy, we can go into the bind of the tissue and take away and go back, and take away. But at the same time we come back and we begin to integrate. So we're working on the whole group as a unit rather that individual groups.

S: Sam, and I presume it's the same Sam, has asked another question about if you're working on T9 what's your point of application? Is it just on the pelvis or is actually on T9 as well?

T: Pelvis and T9?

S: It could be either side of T9, so you could be-

T: Yeah, above and below.

S: -Going towards you or away

T: You can if you want to provide a kind of almost a counter rotation with it too if you want. There's many applications to do. But it's only a subtle movement, you're encouraging teasing and easing. You're going to be then doing more specific work later on. So this is, a lot of the times, a preparatory but at the same time it's very good. For example, if the patient is very sensitive and you just want to provide that dynamic, this perception of movement is going into the- through the proprioceptor side of the nervous system and it's kind of being like perceived at a higher level, including the amygdala, as either a suppressant relaxing effect. Or, if I do this, and I'm doing it too fast and I'm prodding too hard, that is not nice at all is it? Sorry, but it isn't. So that's why its very important that you are picking up the nature of the tissues.

S: You're allowed to be brutal with Kate

T: But at the same time we will utilize the concept of using actual paraspinal inhibition as well within the context of the treatment. But we're providing freedom, but we're looking at actual rotation interossive freedom but also longitudinal.

S: A lady called Evelyn has asked, "Is this the same as Pold method?" Now I don't know what Pold- P-O-L-D?

T: I have no idea.

S: Evelyn, do you wanna give us some more information on Pold method because-

T: When was it developed? By who? Because as I said, there's a lot of overlapping concepts and developments on various components of these methods. But if you look at the gentle origins of this, Little John could be considered to be the father of harmonic treatment. That's how his approach was differentiated from that of… Still aspect of treatment. He was very much into rhythmic movement, he was into the physiology behind treatment, where as Still, perhaps it was also physiological based, but also looked at anatomy and mechanical. So now I'm providing just gentle paravertebral inhibition. This is very nice because we can actually have an influence indirectly on the sympathetic tone. So we have this scenario sometimes where we have this- scenario where we have changes with… this is very good for like dealing with stress, stress components. If you look at the whole idea of the HP, hypothalamic pituitary axis, and do you know what's very significant too? Is if you look at the neuroanatomy, you have the innovation of the actual adrenal system in and around the T9 area. So quite often when people have stress and tension, where do they feel it? Here. And this is typical of that kind of visceral, expression of visceral

S: That wasn't such a good shot for the camera

T: -in this area. So when we're dealing with this context of treatment, also it has the effect of calming, soothing, and that's perceived at higher centers as well.

S: Let's see what we've got in here. Allison has said, "Is it possible to limit the spread of the oscillation or focus it using the right hand while you're palpating?"

T: Yes, you can. You can come to the point, here for example, but if you notice I'm changing the dynamic of the oscillation. I can fix above, so that all the vertebrae, all of it goes to that point. If you want to we can disengage and allow it to come through a little bit further. So it's all to do with propagation in waves, and propagation of the dynamic of movement really. Not excluding

the fact that we can actually provide the circumduction in the shoulder to free up tissues that are a little bit resistant to movement.

S: Jason's asked if there are any typical changes that you can perceive in a dosage of time or do you just perform the technique until positive changes are felt?

T: We usually feel for the change in terms of the nature of the movement under our fingers, but also the expression of the tissue sometimes. If that is there and happening there under our fingers.

S: There's lots of questions here, and I feel like we're sort of distracting you by asking questions. Did you want to just show any modifications

T: For example, yeah, there's a sideline approach. So if you face this way for me. We can put you there. And I'll just put this here. And bring the knees up. So I would like to provide stability in the knees, are we good, Kate, with the microphone. It's not gonna go clink, clink, clink

S: The sound man will sort the microphone out.

T: I'm just gonna move this out of the way if that's okay. Just for a second. So that's been wired up, but there we are there. So now the modification is basically to stabilize the aspect of the thorax and the latissimus dorsi region and we can begin to provide very gentle oscillation. It's also quite good for working with the rib angles as well. Again bilateral. And we might provide pushing down, pulling up in that consequence. Everybody okay with that? So we're gonna focus on that a little bit.

S: This seems much more focused than the previous, the prone technique because-

T: It can be, yeah. I mean you can't be more focused when you're doing the prone, I mean I'm turning the dial up at the same time, but you can be. Again, this is something that you will otoconite within the context of the body adjustment. For example, I would be working later on my, working more specifically, everybody's familiar with this approach probably. But then I would start to work with this to provide some periscapular relaxation of major muscle groups of the scapula. But then I might have to go back and actually encourage a little bit more freedom and those rib angles. And at the same time of course I'm beginning to engage the sympathetic groups. And I might provide, if I find for example, rib fixation I might provide a little bit of rib gaping for example that way.

S: Now this is not oscillation? This is-

T: No, but you can provide it with oscillation too. You can fix on, provide oscillation too as a component. Can I go back to the prone just for a second, if that's alright?

S: Yeah we've got some, we're running out of time

T: I wanted to show how that movement can be modified so it can be used to actually deal with also the-

S: You need your cushions back or are you okay?

T: You alright? Turn you head- sorry I've got to go this way for the camera people forget- turn your head this way. So remember we're doing this bilateral, we don't just do one side we do it... So we can actually then start to work a little bit on the actual costovertebrae angles here as well. So we can start to free that relationship of rib to the actual attachments at that thoracic junction too if you want to. So that becomes very nice if we're working with interscapular tension, but also to provide a dynamic of freedom. For example, very good for working with broncitic senarios, asthmatic scenarios.

S: Don't worry about that. Don't worry about that, that's fine.

T: Okay, and then of course we can provide some very gentle inhibition with a little bit of very gentle work around that area. So there's lots of parameters within the context of oscillation and injunctive things too.

S: And I'm sure we could turn this into a sitting technique as well if necessary, but we can probably leave that to imagination.

T: One second, zip up. Okay.

S: In preparation, do you always ask your patient to remove their microphone first?

T: Yes, if they got one with them. And of course it's that transition from lying to sitting, you have to be observant of because you're changing the vascular dynamics in the spine. You gotta rely on the back reflexives to do their job to stabilize the actual vascular side of things. So quite often there is another way we can apply it, and this also quite often frequently do towards the end of treatment as well, is just to see and apply a little bit of rotation in that mode through the field of that.

So you know, I'm not imitating John Wonan because he had contracted fingers on one side. I'm just getting the fingers out-of-the-way so I can palpate, that was something that came up once on an initial- We can change the dynamic to go left or right if you want to. And there's also a little bit of movement dynamic in oscillation with this as well. So it all depends on what kind of focal point. But ultimately when we're doing prone work, the

difference between us and the other methods that I've developed from this, in terms of their own modalities, is the fact that we use the sacrum and pelvis at the induction point. We don't do too much further up.

The reason for that is because quite often that can create irritation, sometimes irritation, to the vascular field side of things in terms of the ordonomic side of sympathetics as well.

S: Kate, thank you for being a very patient patient. After you.

I got a long question coming here, which actually it struck me as being quite interesting. It comes from Tenith who says she's curious if you've ever treated a patient who you wouldn't HVT because you knew they'd respond adversely in the psychological sense. She's had two patients like this, one is a student, one is a new graduate. "The tutor warned me not to manipulate her strongly as it would send her to the hospital." Under the guidance of another tutor she did a manipulation and the patient did wind up in A&E with a severe spasm requiring local anesthesia. Are there any signs to warn you of this sort of thing in your experience? And P.S. the other patient asked her not to manipulate. She later discovered it was because she'd had a rough childhood and only wished for gentle hands, in inverted commas, I didn't see any overt signs. She was a successful business person hence the question.

T: Okay, well, I suppose it comes down to the consultation that you had, the information that you managed to get from the patient, in your question and answer time in terms of formulating your case history. But in terms of the question and when to and when not to HVT. For me, if I find that there's any region of sensitivity there within the spine, when you're gently palpating and you're doing your dynamic movements. And there's any indication of any inflammatory parameters going on, or there's a situation where there is just not any tissue compliance as your freeing the tissues and there is that-

I don't necessarily go and work with HVT. The instance is that when you're dealing with patients a lot of the time with chronic scenarios, chronic pain, et cetera. It's quite often that you're using that body adjustment prose that I'm doing to actually just work with the adaptive tissues and compensatory adaptive tissues over time. And you're dealing with A) getting the patient familiar with your approach and B) getting the confidence in your handling. And then at the time, when you've done enough preparatory work, and that might not necessarily mean at that time of treatment that might be two or three weeks away. Then you start to gently spring the tissue and see what the tissue response is and if you know the patient can tolerate that then you say, "Okay, now I'm gonna provide a gentle, long lever fulcrum approach. I don't use any HVT thrusting movements." All the movements that we're relying on is very simple long lever applications.

S: Graham, in Devon, said he'd be interested to know how many of the professional audience tonight uses this oscillation technique. And, I suppose, I'd develop that and say well is this the same as Letterman's technique? I don't think it is quite. This a protocol in its own right for treating-

T: Yes, but if you look at the writings of Zachary. And if you look at the writings of-

S: A.L Letterman.

T: They all have that same concept of movement harmonics. And that is, in all respects, similar.

S: Well it'll be interesting to hear from you, watching, whether you use this or a version of this. And I apologize to one of our viewers who's already said that it's weird that they've already used something like this technique.

T: I would stress, if I may, is that this modality or this approach of this oscillation is done within the context of the body adjustment, it's not done in isolation. And if you look at the writing of Zachary Gomez he talks about that as an adjunctive method to a lot of my official techniques as well.

S: I've got a question that's coming from somebody in the audience. I don't think we have a name for this, but also a related point of my own. One which, of course, we're now very keen to examine in most treatment scenarios. My question is in terms of getting patient consent, whether you call it valid or informed, and of course there's a little bit of debate as to what those terms mean. I would imagine that the possible adverse outcomes of this are very, very rare, if any. Nevertheless, you have to get some sort of consent from your patients, so what do you prescribe to your patient as being the benefits, the possible contrary indications, the alternatives, and how do you go about getting that consent?

T: For me, that usually happens at the time of case history, taking the case history. Then, usually I explain to them what the context of the treatment will involve. And for them, I give them the idea, mention to them that this is a standard approach that I'm using and it doesn't vary very much in terms of what they may perceive it to be. But they do, quite often, perceive differences because they quite often say "Oh that's something different." But going back to the consent. Usually as long as they are- I've given them a description of the mode of treatment I will give, and the reason behind because I always give an explanation as to how I'm doing things. Then I will say to them, "Okay are you in agreement with that?" And my case history, I have a little box, yes or no. And they always sign the case history after I have given them- I'm fortunate-

S: After you've treated them?

T: No, before I've treated them. I've always done that since the standards of the GCRO recommendation presented that scenario to us.

S: You're showing your age with the GCRO now.

T: Oh sorry GOC. But you know we used to have, I mean you do in UK, you have that beautiful document that and you can sign, they can sign. They see that as a legitimate documentation. So I haven't got that in Belgium, but I have the equivalent on my case history. I'm fortunate, also because two of the practices I work in, I'm working with primary healthcare physicians. So they're doctors. And they will quite often refer patients to me, so I know that they have given, that they're familiar with how I- I treat them as well, so they're familiar with the way I approach. And safety is an issue for them because for me to be working there as an osteopath to them it's quite.

S: I don't wanna… particular name on the side. First of all, we're all required to do something on the topic of communication and consent so you can tick that one off on what your CPD record, osteopaths, for this broadcast. But of course if we had a purist discussion about this, many people would say well actually if you were in front of the Professional Conduct Committee, they would argue that a lot of the things that you said aren't good enough. No, I'm not metricizing you here, because the PCC will find all sorts of ways argue that your communication consent isn't adequate. And it's very hard to satisfy them.

Moving back to the question, the part that came in from a member of the audience, says, whoever it is says, they like these techniques and use them selectively, but is there a way that you could record specifically what you have done to the patient? Well you can easily say, "HVT. Or C23." Or this is little more tricky perhaps?

T: Well, within the context of the treatment, usually I will be a bit more specific as to the nature of the treatment I'm giving. So, for example, when I go for the body adjustment, I go GBA, but I also put more specific detail. So I will say, "SI Springy. Parascapular release, this region. Thoracic adjustment knee segments" for example. And I will also say what the actual patients perception of that was. Was that okay?

S: How long are your treatments?

T: My treatments are about half an hour to 45 minutes.

S: There's a lot to do in that time isn't there if you're recording-

T: Yeah but you know you do the GBA within about 27 minutes to a half an hour to 45 minutes tops, you don't over-treat. When you get familiar with it, you just work within that time frame. When I'm working with babies, I don't treat more than about 10, 15 minutes. 20 minutes tops. Because you can over-

treat if you're not careful. But yeah there are these issues, but I think you know what do you put down? I've got a little thing, that I've been playing around with, I like ICT. I've kind of like schematic, a bit like the soap thing that the Americans have. So I have regional things and I do GBA, but if there's any more adjunctive specific kind of things, I tick a box. And it's labeled and that comes in as a technical file for my documentation.

S: I'm gonna pick up on two things before we have to close this evening. First of all, whoever it was asked us about the Pold methods says, "It's a physio technique. Dynamic, rhythmic, or saltatory mobilization." And they've given us the reference for it, which is sciencedirect.com reference, which we will put up on the website-

T: Yeah, that's interesting.

S: That will be interesting to look at. And the next things is something that you spoke about, and again another unnamed viewer, has said "Isn't spinal manipulation beneficial for the vertebral venous circulation?" You mentioned earlier on.

T: Yes.

S: Little John for every mechanical operation there should be a physiological reason or something. Would you give us a very quick burst on arterial, venous effects of what you've done? I know you said you had some pictures or things like that, but we may not have time to got through the slides.

T: Yeah but they'll see the slides.

S: We'll put them up afterwards-

T: What we are doing, as we are providing that osculatory dynamic, is we're actually providing the opportunity for those vascular beds, the vasculartho rn for example to the segments, to become reflexive dilatory depending on the nature of the treatment, because sympathetic is constrictive sometimes. Depends on the nature of the treatment. Of the receptors. But what we're doing is finding a pumping mechanism there, and as long as we're getting the venous congestion away, the avascularization of the cord would be induced too. So that's what we're doing. That's what we're encouraging. John Renomore used to say "Don't forget that the spine is another organ in the body." He didn't see it as purely a column of vertebrae. He said "That is a physiological, living structure." And it is, for him, it was the medium through which the brain processes reflexes.

S: Tim these things fly past don't they?

T: They do, they're very quick.

S: You think 90 minutes is gonna be a long time to fill, but actually think we've covered a lot of stuff but actually there's still loads that you could've gone on to show.

T: Yes.

S: I don't know who this is but someone says, "Thanks, Tim. I've really enjoyed watching this evening." And it's encouraged them to reflect on their current treatment method.

T: Yeah

S: Which of course what we want isn't it? What can we incorporate, what can we -

T: I think the wonderful thing about what I do, and what the institute does, is that we don't throw things at you. We kind of like say "Well this is a concept based on these observations, these ideas." Look at it today, how it is applied, and look back at the history. Look at what Louisa Burns was doing in terms of research on osteopathic lesions. How does that relate nowadays to Gary Fiers model, which you'll see

How does that relate to the concept of interior reception, exterior reception? How does that relate to the whole idea of the-

S: We know what you mean. Yeah.

T: And Little John talked about the environmental lesions, the BSM of the past, is… these things interconnect. And I love bringing that context in, so we don't lose our identity in terms of our history and our philosophy of what we do. But at the same time, similar ideas develop and evolve, and it's interesting to see as per this book and other books and other modalities and other peoples. How this system interacts and, for me, it's very valuable because it means our hands on approach on body work, has the potential of helping a lot of people.

S: It does. And I think we all know that. The trick is, of course convincing the conventional world that we can do this-

T: You know I'm in the fortunate position, sorry, that I once in a while, will do like a discussion over sandwiches with three young doctors. And I'll say "Whats the theme today?" And we'll talk about asthma, so I talk about asthma. They look at their way in which they approach it, I talk about it, and I actually give them treatments to how we work with asthma. And then I say to them, "What's your quack?" Questions, like you know quack. So one of them came up to me and said "Well I've heard about this idea of visceral balancing. What's that about? Because a patient of mine came in and said they had their

liver balanced. What the heck was that all about?" She swore, she used the F word, it would have beeped because she was like "ugh."

Well I said, "What kind of context do you want to put that in? Do you want that in terms of new physiological function of the liver? Or are we talking about the suspensory ligaments? Are we talking about the actual metabolic function of the liver?" And then I'll say "Okay, here's a bit research on certain parameters of liver function after a hepatic pump has been applied. Here is a splanchnic pump. Look at the research on changed ESR levels in the blood as a consequence of splanchnic." So then they see this evidence based material that's in these journals and then they're like, "Oh this has been researched." So, they're not critical, they become curious, but you have to be proactive with that.

S: Tim, we're gonna have to change all the certificates, we're gonna have to tell them they got 92 minutes CPD-

T: I'm very enthusiastic about what we do. Well thanks so much for inviting us.

S: It's great to listen to you-

T: I loved your questions.

S: Because you're very knowledgeable and there's a couple of questions, two or three questions, that have come in if you don't mind me putting to you afterwards-

T: Yeah and I could give some nice answers to that. That's no problem.

S: It's been-

T: I'm very grateful to be invited.

S: Great. Thank you so much.

T: Thank you very much for watching.