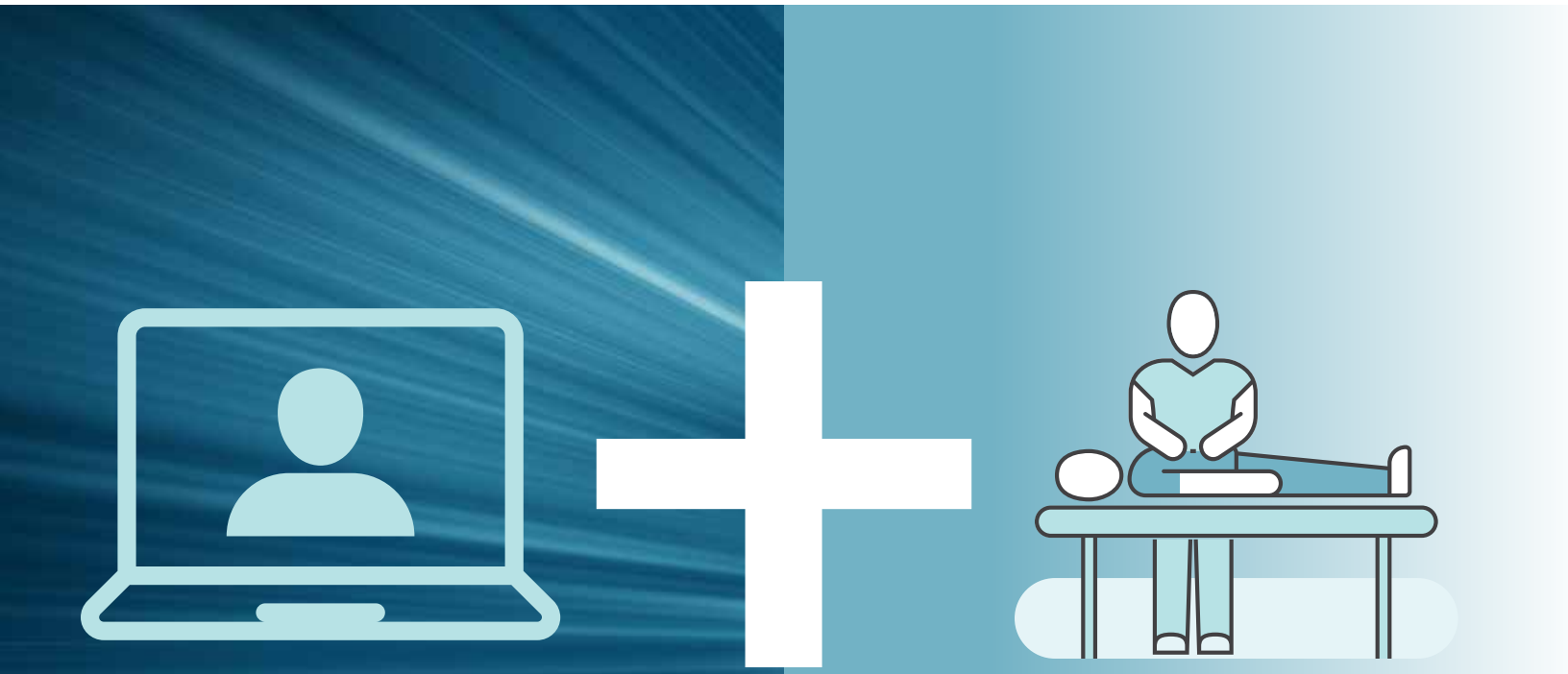
The Cranial Letter

THE OSTEOPATHIC CRANIAL ACADEMY, INC.

A Component Society of the American Academy of Osteopathy

Volume 73, Number 3 | Third Quarter 2020

New Introductory Course Combines Online, In-Person Learning ... *Coming in November*



Inside

The Osteopathic Cranial Academy

Introduction to Osteopathy in the Cranial Field

New hybrid format
Coming this fall

Virtual lectures

Online learning will take place over a four-week period Nov. 9 through Dec. 13. Participants will be able to watch 4.5 hours of lectures on demand each week. At the end of each week, participants will join in a mandatory hour-long discussion group via Zoom.

Regional in-person labs

3-5 local/regional labs will be held at selected sites across the country. The labs will run for 10 hours a day over three days including a weekend. The labs will be similar to those at previous Introductory Courses, with hands-on instruction by experienced trainers.

Watch your email and cranialacademy.org/cme
for further details including dates and locations on this exciting new offering!

The Osteopathic Cranial Academy

The Cranial Letter

Official Newsletter of
The Osteopathic Cranial Academy
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James Braibish, APR

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Volume 73, Number 3 | Third Quarter 2020

Contents

Mission

To teach, advocate and advance osteopathy, including osteopathy in the cranial field, as envisioned by Andrew Taylor Still, MD, and William Garner Sutherland, DO.

Vision

- To promote mastery in the practice of osteopathy in the cranial field
- To support a vibrant professional environment so that osteopathy can flourish
- To establish osteopathy, including osteopathy in the cranial field, as a recognized cornerstone of complete patient care

(Comm)unity of OCA Members Rises to the Occasion

By Annette Hulse, DO
President, Osteopathic Cranial Academy 2019-2021

Annette Hulse, DO, is an osteopathic physician in Santa Cruz, Calif.

Our members have stepped up, innovated, imagined and created different ways of teaching and also of connecting.

The body is a unit. It seems like such a simple statement, and yet—like all profound truths—there is a lifetime of wisdom packed into it. I have been thinking about how this fundamental truth of osteopathy also applies to other kinds of "organisms" at a meta level, namely groups of human beings. Unity is so important for health—the health of us as individuals, as a profession, as a society, as a planet. And now, at a time when we all need it most, the OCA and our members are finding more health by leaning into the strength that comes from (comm)unity.

At this point in history, the OCA can't do what we do best—share the wisdom of osteopathy with hands-on teaching. And yet, our members have stepped up, innovated, imagined and created different ways of teaching and also of connecting. There are so many individuals whom I would like to thank for their involvement that I don't have space for them all; the sheer number of individual members who have made contributions to our community in the past few months is astounding. It is a sign of health of the OCA, but even more importantly, of our profession.

Let's start with the Virtual Conference in May-June. The members of the Virtual Conference committee (Chair Dr. Dan Shadoan, along with Drs. Dennis Burke, Ali Carine, Mel Friedman Maria Gentile and Ilene Spector) did a herculean job creating and putting on a wildly successful conference plan on extremely short notice. In doing so, they helped fill many needs in our community, from need for CME to need for stimulation in the midst of quarantine cabin fever, and of course, need for professional and personal connection. The fact that almost 500(!) members and students attended at least one of the six sessions of the Virtual Conference demonstrates how important this event was, and how well it met the needs of our members.

Of course, the 26 speakers we heard during the Virtual Conference also deserve a huge thanks from us all. They put in an amazing amount of work to prepare the clinical pearls, stories and anatomic findings and nuances they shared with us, again working on a very short time frame. We started with the searing stories of the COVID front lines from Drs. Ettlinger, Katrajian and Egerter and ended with a fascinating reflection on the teachings of Dr. Sutherland in the 2020 Sutherland Memorial Lecture by Dr. Doug Vick (which, by the way, you can read in this issue of *The Cranial Letter* if you missed it in person). Our speakers represented all of the important aspects of osteopathy through a variety of lenses; the members showed their appreciation through the amazingly high speaker evaluations that we received.

In August, Drs. John Reed and Reem Abu-Sbaih facilitated a discussion about diversity and inclusion in the osteopathic community. I so much appreciated their willingness to start this important conversation in our small group, at a time when our country grapples with the ramifications of decades/centuries of racism and exclusion.

From August through this month, Membership Committee Chair Dr. Julie Mai has put together several "Share and Learn" Zoom gatherings to help us learn

from each other about aspects of osteopathic practice, including working with pediatric populations and business elements. Special thanks to Frank Cyr, who has generously shared his expertise with us.

New Course Formats Developed

Coming up, our Introductory Course faculty, led by Course Director Dr. Richard Smith and Intro Course Committee Chair Dr. Zina Pelkey are pivoting to a new way of delivering the 40-hour Introductory Course, in a way that preserves the best aspects of OCA teaching but also maintains pandemic-era safety. This hybrid course will deliver the lecture portion of the Introductory Course with small regional lab sessions limited to no more than 10 students in one place. It has required the Intro Course faculty to start from scratch in planning how they deliver and connect the various parts of an Intro Course—more innovative work from yet another group of core members of the OCA.

And last but certainly not least, over the past year, prior to COVID-19, Drs. Maria Gentile and Wendy Neal put in a tremendous effort to create an entirely new Introduction to Fluid Course for the OCA, which was originally scheduled to be held in-person this fall. Since that course had to be postponed indefinitely due to the pandemic, they have created an online course instead. They have had to create a new course not once, but twice, and in two different formats; so I would like to give them even extra thanks! The virtual six-hour Introduction to the Fluid Course will be November 7-8, and registration is now open (see article below).

Our Introductory Course faculty are pivoting to a new way of delivering the 40-hour Introductory Course, in a way that preserves the best aspects of OCA teaching but also maintains pandemic-era safety.

You see what I mean by all the many contributors who are supporting the health and (comm)unity of the OCA! I am so proud to be a part of this organization as we step up and lead our profession during a time of chaos and upheaval, and proving that our members always are, and always have been, our most important asset.

Dr. Hulse can be reached at president@cranialacademy.org

Introduction to the Fluid Course to Be Offered Virtually Nov. 7-8

The Cranial Academy is pleased to offer a special Introduction to the Fluid Course virtually on Saturday and Sunday, Nov. 7-8, 2020, from 12 to 3 p.m. Eastern (9 a.m. to 12 p.m. Pacific) over Zoom.

This intermediate course presents didactic components that will be explored in greater depths at our in-person Fluid Course, which has been postponed to 2021 due to the COVID-19 pandemic. The aim of both the in-person Fluid Course as well as this virtual course is to build on the basic fluid concepts from Introduction to Osteopathy in the Cranial Field and deepen your understanding of working with fluid as a diagnostic and therapeutic force.

For the upcoming virtual Introduction to the Fluid Course, the focus will be on developing an expanded understanding of the anatomy and physiology of the cerebrospinal fluid and its pathways, as well as different properties and qualities of various fluids and fluid compartments in the body.

The course will be looking more deeply at fluid in the central nervous system, the extracellular matrix and the vascular and lymphatic compartments. It will also discuss the interactions between these compartments, the continuity of fluid throughout the body, and the concept of a contiguous fluid body.

The roles and relationships of fluid will be explored, both in life and throughout nature, including Dr. Still's concept of biogen. The program will also delve deeper into the interaction of fluid, tissue and a sense of the potency that infuses the fluid, and its dynamic, living, responsive, reparative potential.

Course directors are Maria T. Gentile, DO, of Denver, Colo., and Wendy S. Neal, DO, ND, of Portland, Ore.

For more information and registration, visit www.cranialacademy.org/cme.

Thank You for Supporting the Virtual Conference

The Cranial Academy's Virtual Conference May 16 – June 27 was a great success. Nearly 500 OCA members and students attended at least one of the six sessions.

Assembled in just a few weeks following the cancellation of the Annual Conference due to COVID-19, the Virtual Conference featured six four-hour CME sessions.

Ali Carine, DO, speaks at the third session of the Virtual Conference.

Native American-Affiliated College Opens

Oklahoma State University Center for Health Sciences and the Cherokee Nation have established the nation's first tribally affiliated college of medicine in Tahlequah, Okla. A virtual white coat ceremony for the inaugural class of 54 students was held in early August.

The new OSU College of Osteopathic Medicine at the Cherokee Nation is an additional location of the OSU College of Osteopathic Medicine in Tulsa. The new campus is intended to help recruit Native American medical students and give physicians primary care experience in serving rural and Native American populations.

OSU has had a clinical rotation at the hospital in Talequah since 2006 and a family medicine residency program there since 2009.

Rendering of the OSU College of Osteopathic Medicine at Cherokee Nation.

OCA "Like Family" for 25-Year Staff Member

A familiar face at Cranial Academy conferences and the OCA office since 1995 has been operations manager Jenny Southworth. She is the backbone who helps to keep the events and other aspects of the organization running smoothly and seamlessly. And, her infectious laugh lightens everyone and ensures the mood remains on an even keel.

This past May, Jenny celebrated her 25th anniversary with the Cranial Academy. It all started in 1995 when a friend passed the word to her that the friend's mother—former OCA Executive Director Pat Crampton—was looking for an assistant.

"I thought it would be a temporary job, maybe just helping out at the Annual Conference," Jenny recalled. That was 25 years ago, three executive directors and many friendships since.

The camaraderie and spirit of the OCA soon captured her. "The board members were a great help in teaching me about cranial osteopathy—which I knew nothing about," Jenny said.

OCA also showed her its lighter side with a costume dinner that first year. She remembers Dr. Viola Frymann dressed as an alien. Another physician was dressed as Dr. Frymann. Jenny likes to highlight the fun moments but also makes sure the job gets done.

> "Whenever there is a need, our members always are willing to chip in and help."

"Our members have the greatest sense of humor. They are very giving … and forgiving. The whole organization is amazing," Jenny related.

"We've all become like family," added Jenny. Indeed, her husband, Charlie, and daughter, Molly, also help at the Annual Conference and are well-known to members. Molly, now 15, is trained to oversee registration. Charlie, who works in logistics, prepares the training tables and other supplies for shipping to the event site.

When she's not helping her mom, Molly is an active high school student and aspires to be a doctor or engineer. She holds a second degree black belt in Taekwondo and enjoys swimming. She is a member of the school marching band and plays saxophone, piano and guitar.

And, Molly has been to every Cranial Academy Annual Conference except for three during her lifetime. Both Molly and Jenny have received OMT treatments at the conference. The family also sees Charlie Beck, DO, FAAO, in Indianapolis.

Outside of work, Jenny and her family enjoy traveling. She notes Devil's Tower National Monument in Wyoming and Sequoia National Park in California as her favorites. They also enjoy kayaking and movies. And this summer, they've put together outdoor film showings for their neighborhood as a socially distanced fun activity.

Jenny Southworth with her daughter, Molly, left, and husband, Charlie, right, at an OCA Annual Conference. *(Photo by Mark Rosen, DO, FCA)*

On Jenny's contributions to the Cranial Academy, President Annette Hulse, DO, shared these thoughts: "Jenny is on the front line of interacting with our members, whether it's by email, on the phone, or in person at conferences and courses. She is a pleasure to work with, and we are very lucky to have Jenny as the warm and welcoming face of the OCA."

Jenny summarized her experience with Cranial Academy members. "They are very generous with their time and resources. Whenever there is a need, they always are willing to chip in and help."

When I Wake Up I Hear Crying

By Steve Paulus, DO, MS

Increasingly, during this time of pandemic, I wake up in the morning and hear crying.

As I shed the veil between my sleeping state and the waking world, I attempt to discover the source of this sorrow. Have I been crying, in the otherworldliness of my dreaming state? Or, am I "hearing" the sorrow of the waking world; this grandly distorted new pandemic perspective of my family, friends, patients, community, and in a greater sense—all people suffering right now in these worst of times?

Whenever an intense emotion emerges within and about me, my tendency is to become an explorer. When I explore, I like to prepare for the journey. I gather my maps, carefully select the essential tools, sharpen my knife, and organize for what very well could be a long expedition. Some of my journeys take a lifetime. Others are briefly passionate. All emphasize the need to search within rather than project outwards.

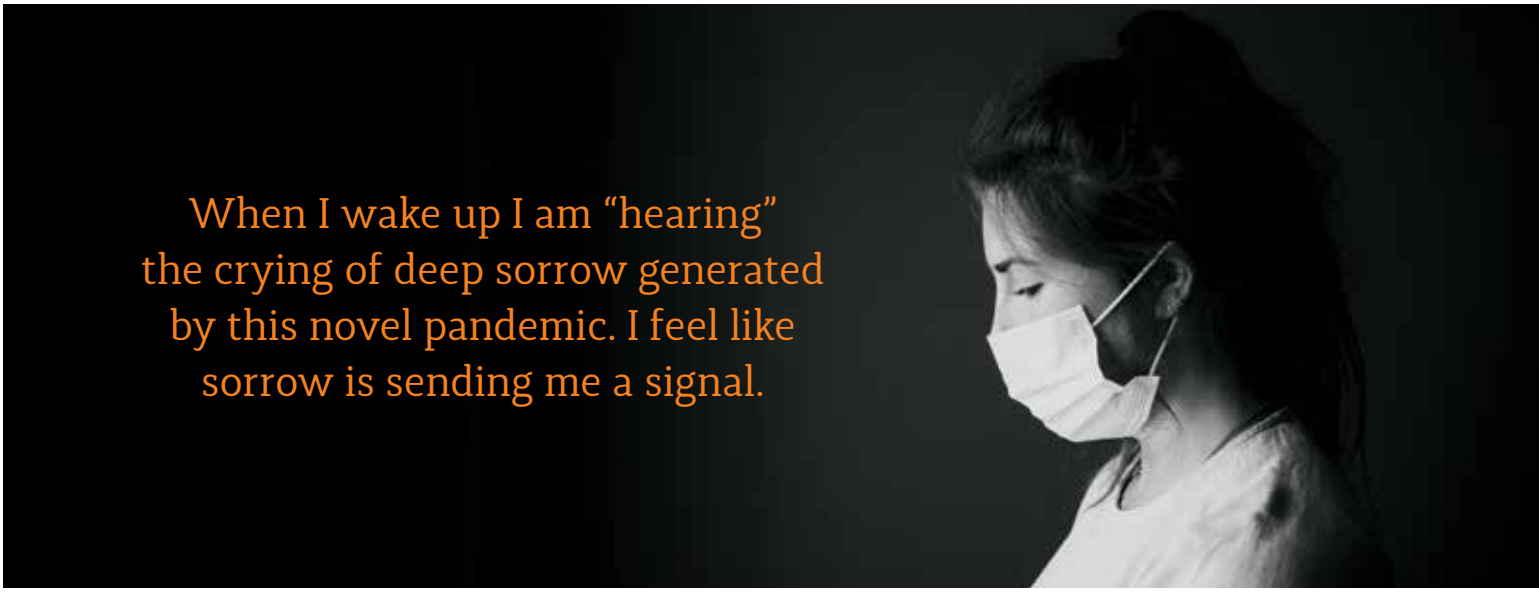
> I care for a lot of patients who are struggling to hold on to their stability. Maybe I could say, sanity. They live alone, under quarantine—cut off on many levels.

One of my maps is language, especially the philosophy of words, their deeper meanings and the conscious and unconscious substance that drives understanding. Yes, I did use the word substance to describe "conscious and unconscious;" more on that later. But, before I can explore the intricacies of language, I must find the word that defines this journey. Maybe one word is insufficient? Sometimes the journey begins with a poem or a quote. Or more commonly, initiation just begins with a deep feeling that does not yet have a name.

If the journey begins undefined or poorly formed, all is not lost. In this common situation, I then know that I must prepare for a long journey. Gathering the proper tools becomes even more important. Patience then becomes an indispensable tool. I know from experience that when the edge of patience becomes dull, the integrity of my journey falls apart. Sometimes the most important journeys end with a whimper, not a bang. Patience is not the word defining this current journey. But, starting this odyssey without the sustenance of patience would be impractical, and doom me to aimless wandering.

The late, great Anne Wales, DO was fond of saying that, as Osteopathic physicians, when we are with a patient in a clinical context that we must, "be patient and wait some more." She was referring to the need for us to respect the unique tempo of healing that every individual possesses. I love this simple, paradoxical and poetic expression. To be patient and wait some more tells me that I must not take the need for patience for granted. To change metaphors, being with all that patience means, could very well be the map that guides me on any meaningful quest.

Steve Paulus, DO, MS is an Osteopathic Cranial Academy member in private practice in Shelburne, Vermont. This article was originally published as a blog at www.stevepaulus.com.



I know the word that distinguishes this quest—sorrow.

What is sorrow?

Sorrow is a feeling. It is a core emotion. We all have experienced it, and it is always available. To deny the existence of sorrow would be to deny the existence of its counterpart, joy. Sorrow is different than sadness. Sadness does not always include loss. But, a little bit of sadness is somehow contained in sorrow. Yet, sorrow has a particular air of dignity. There is a certain lack of distress in sorrow, but not a lack of intensity.

Sadness can be either a very common, simple daily emotion or the leading edge of depression. Whereas, sorrow is more closely akin to grief. Or, maybe the formula is: sorrow = grief + sadness?

I have never stopped seeing patients during this terrible pandemic. My days are longer and more effortful. I am not an emergency room doctor or ICU intensivist on the leading edge of this terrible war. I honor the commitment and sacrifice of my brothers and sisters who serve at the extreme front lines of this pandemic. I fight battles from the relative safety of a private practice office, not the hospital. I gave up hospital work 25 years ago to devote my medical life to the care of people who suffer with chronic and acute pain, and all the associated consequences. I have organized my office to spend quality and quantity time with each patient.

I have been reflecting lately on the term, "frontline doctors." Who is frontline and where do we draw the line? The war-like metaphor seems appropriate in this war-like event, or is it? Are the soldiers at the edge of the line the only soldiers in this conflict? Is there a "we" in this war effort?

I care for a lot of patients who care for a lot of patients. I see doctors and nurses in my office who are part of the extreme front line, who are dedicated professionals struggling to care for the very sick, while struggling to care for themselves. The deep existential fatigue they project is frightening.

I care for a lot of patients with frail elderly parents or those with spouses struggling with serious illnesses. These caregivers form a foundation of support for their family, outside of the medical system. They too are stressed, overwhelmed, and exhausted.

I care for a lot of patients who are struggling to hold on to their stability. Maybe I could say, sanity. They live alone, under quarantine—cut off on many levels. Or, they live with a partner and have felt isolated even before the pandemic; now they suffer with an even deeper loneliness that, I can tell, is leading down the road to depression.

I care for a lot of patients with complicated medical problems. They may need surgery, but cannot get it. They need to see a specialist, but those offices are closed. They need, they need, they need …

I care for an emerging set of patients who are not experiencing a loss of life but a loss of lifestyle. I am seeing the first patients needing to declare bankruptcy or are preparing to lose their homes because they have lost their jobs. Their road is not just bumpy. They have lost the road altogether.

I struggle to care for myself so that I can continue to care for others. I allow myself to be a safe port in a stormy sea for my patients. I toil to protect myself from infection while being a doctor testing for coronavirus, treating sick patients, and caring for the emerging next wave of pandemic, that of mental illness.

continued

I realize that sorrow is not an endpoint but a gateway to healing.

Every day, in my humble outpatient office, I am seeing the fabric of our society fraying. Part of my sorrow is based upon worry. I work hard to not let worry be transformed into fear. The media is not making it easy for all of us doctors caring for patients. The contagion of fear is fiercely and rapidly spreading. The media define frontline doctors narrowly. I don't define myself with this label. I prefer not to segregate. I don't need recognition, applause, or someone placing a sign on their lawn thanking me as a "frontliner." Every doctor who is still seeing patients is doing what they are trained to do. I am a doctor. I care for patients. This is what I do.

I try not to lose sleep. Maybe I am not trying hard enough, because for the first time in 35 years of being a doctor, I am losing sleep. Maybe it is me crying in the night?

What is the common thread linking all during this time of pandemic? Sorrow.

Let's return to the existential meaning of sorrow. Sorrow has a component of mourning, bringing us back to grief. Perhaps the real root of sorrow is grief?

One of my many ongoing journeys in life has been to study grief and all of its consequences. More and more I am finding that for me, grief holds the key to understanding what it means to be human. Sometimes it feels like grief is more of a companion, than the objective of my journey. Grief has many faces. My journey with "the griefs" feels crowded at times.

The pandemic is not making me sad. The pandemic is filling me with grief, but the feeling is different than the garden variety grief (based upon loss) that I am used to. This grief is different. When I wake up I am "hearing" the crying of deep sorrow generated by this novel pandemic. I feel like sorrow is sending me a signal.

When I look back upon my life, I "see" many episodes of sorrow. I can use the map of past experiences to know that after each of these smaller journeys, I learned something. They were the cutting edge of growth. Each experience of sorrow has brought equanimity combined with maturity.

There is a confidence in knowing that I made it through sorrow before, and I can make it through again.

I realize that sorrow is not an endpoint but a gateway to healing. Sorrow is not a medical diagnosis. It is not even a problem, unless you make it one. We all face losses. We all know uncertainty. We all know trials and tribulations. Sorrow is a normal human condition that can inspire growth.

There can be a vitality to sorrow that is not present in sadness. I feel that sorrow stimulates the drive to understand and generates the discipline to endure.

Let's return to my previous allegation that the conscious and unconscious is a substance. Sometimes the non-physical and non-local connections with people that I know and who know me is palpable. Carl Jung spoke of the collective unconscious that unites all of human kind. The knowing of unity is not just comforting, it is life sustaining.

What is that feeling, or that something, that connects us with a fellow human being? It feels sometimes like I can touch the connection. Do you know that state of consciousness when you have forgotten a word and it is "on the tip of your tongue?" This substance feels just out of reach, but the connecting of the consciousness of one person to the many and the many to me is real. We are a collective.

I wake up in the morning and hear crying. I hear your sorrow and it moves me. I can touch the substance of your grief, and please know that I understand.

We can make it through these terrible times together. Together, that really is the only way.

To all my family members, friends and patients, please know that I have embarked upon an important journey. I am prepared. I have gathered my maps, carefully select the essential tools, sharpened my knife, and organized what very well could be a long expedition.

I know that I will not be making this journey alone. You will be with me and I will be with you upon your journey. May we hold hands along the way. ◂

Applications for Membership

May 1, 2020 to August 26, 2020

REGULAR MEMBERS*

Amelia L. Bueche, DO, Ashland, OR
Noel Pense, DO, Chandler, AZ
Alyssa L. Tonelli, DO, Yorba Linda, CA

ASSOCIATE MEMBERS*

Leyna Bautista, MD, Cambridge, MA

REINSTATEMENT MEMBERS*

Allison Atkin, BSc, MSC, DPO, Australia
Hilary Baer, DO, Tacoma, WA
Elizabeth C. Clark, DO, Lewisburg, WV
Jasmine Constanzo, DO, New York, NY
Sarah Curtis, DO, Aurora, CO
Joanne Genewick, DO, Mankato, MN
Alaina Klene-Bowns, DO, Grand Rapids, MI
Francisco Laboy, III, DO, Las Cruces, NM
Christopher A. Medina, DO, San Antonio, TX
Avtar R. Moore, DO, Lexington, VA
Victor A. Nuno, DO, Vallejo, CA
Jenisa Oberbeck, DO, Meridian, ID
Richard G. Sloan, DO, Meridian, ID
Andrea W. Soule, DO, Portland, OR
Nathan Williams, DO, Fort Worth, TX

INTERNATIONAL MEMBERS*

Tink Gee, DO, Australia
Ben Stringer, Australia

**If no written objection is received within 30 days of publication individuals who have made application for Regular Membership will be accepted as Regular Members.*

A Call for Osteopathic Stories

Dear Colleagues:

I'm collecting stories to include in a book about Osteopathy.

I'm looking for stories about patient encounters that were particularly poignant, significant, and/or moving for you personally. We touch our patients every day, but I'd like to focus on how ***they've*** touched, moved or changed ***us***.

In your narrative, I'm asking that you tell your story about your patient, what transpired and the significance of the moment.

You can submit one or more stories that you feel are particularly special for you. Please remember to change patient names for HIPAA protections.

Please send your stories to:

Maria T. Gentile, DO at
osteopathicstories@gmail.com

Please include:
Your Name
Practice Location
Contact Information

Remote Osteopathic Treatment

Tuning into the energy of the patient's primary respiratory mechanism is the basis of in-person treatment … we can accomplish it remotely, too

By R. Paul Lee, DO, FAAO, FCA

With the COVID-19 pandemic, I have experienced a healing. I am more aware of the importance we as human beings have for each other. I realize what an impact a careless act can have on another. My close relatives, with whom I need not wear a mask, feel more intimate with me despite their constant accompaniment. Rather than expose my closest relatives to the coronavirus, I decided to retire from clinical practice, something I swore to my inquiring patients over the last several years that I would never do.

But the decision has given me a new perspective. I am free to do as I please, truly liberated. Now I have to watch to see that I don't overdo, or take on too many projects. I have to pay attention to my energy expenditure and my health even more. My consideration of others is matched by my consideration of myself. I even feel closer to "Dad," as Dr. Sutherland called his Maker. Be close to your Maker, he said. We can make use of this unnatural time to access a natural healing.

But, beyond these insights wrought by the adversity of aloneness and day-to-day sameness—"Let's see, this feels like Sunday again"—I have stretched my boundaries to include the reality of energetic treatment of a few patients who requested I work on them remotely. A dozen or so people with whom I am well acquainted are regular clients in this situation of separation—connected only by Skype, Zoom and FaceTime. The patient calls me on my cell phone at the appointed time, and we talk a little to see where they are with their condition and then we hang up and the patient assumes a comfortable position while I go to work on them. Once I finish, I return the call and we wrap up the session and perhaps reschedule. A check arrives in the mail, and life goes on.

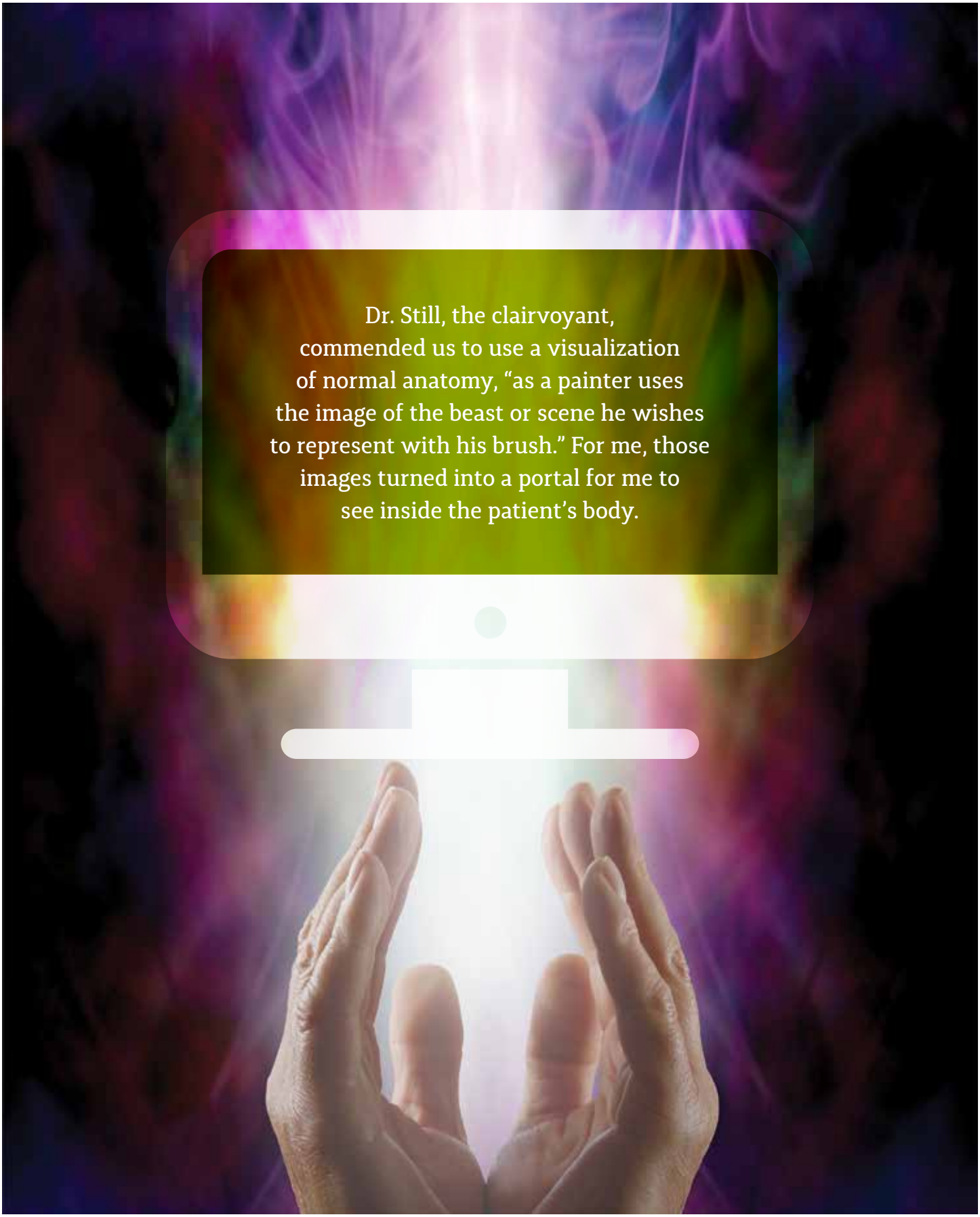
How does one accomplish this energetic engagement? Well, I am still experimenting and discovering, but some basic principles have begun to precipitate out of the experience of the last few months that I want to share. I know many are doing some of this and others have a fantasy about doing it, but we feel obliged to keep it amongst a small group of friends and family without admitting that we are doing something that would usually be considered taboo. With that said, here goes.

Most osteopathic physicians might consider remote treatment to be too weird to entertain and would call it outside of osteopathic philosophy and therefore, not professional. My patients with whom I am performing this outrageous dance that is not covered by insurance seem just fine with it, especially when they feel better. "My molars are meeting for the first time in years." "My headaches are gone." "I can see more clearly." "My tremor is less."

I first entertained the idea to explore remote treatment when we were discussing how we might actually teach an osteopathic conference by Zoom. I had practiced some years ago when I was introduced to it by a clairvoyant. We worked on a couple of people together, and I "saw" how it worked. I am not clairvoyant, but my experience with meditation tunes me into the energy in an intimate fashion that enhanced what I became very familiar with while treating thousands of patients over the years. When we tune into the primary respiratory mechanism, we tune into something that has a basis in pure energy. That energy becomes so accessible with years of experience, so ordinary that we forget it is purely an energetic phenomenon.

continued

R. Paul Lee, DO, FAAO, FCA, retired in June from his practice in Durango, Colo. He has taught a variety of courses for the Osteopathic Cranial Academy and is the author of *Interface: Mechanisms of Spirit in Osteopathy*. He can be reached at osteopathic@frontier.net.


Dr. Still, the clairvoyant,
commended us to use a visualization
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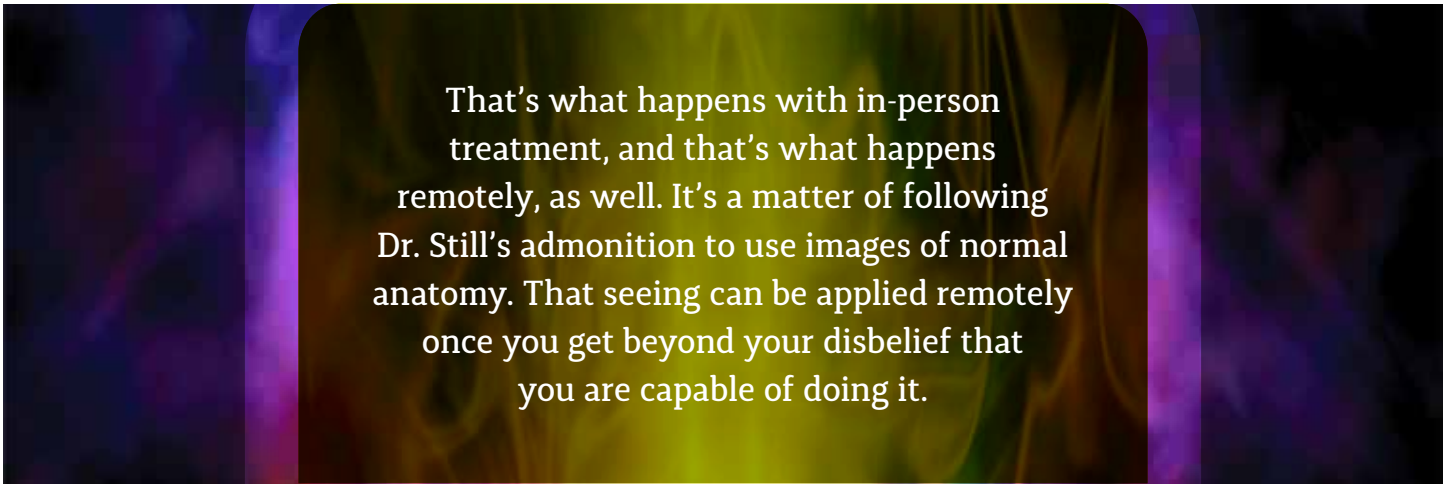

Dr. Sutherland said it was the product of the Breath of Life, Dr. Still's "life force." Dr. Still, the clairvoyant, commended us to use a visualization of normal anatomy, "as a painter uses the image of the beast or scene he wishes to represent with his brush." For me, those images turned into a portal for me to see inside the patient's body. I could see how the sternum was compressed from a trauma many years earlier from a lateral impact that jammed the ribs. What is real is the potency of the fluid—another energetic phenomenon that will unjam the ribs and sternum when my attention is placed there at the fulcrum of the damage.

Perceive the restricted motion, and find its center. There we find stillness. That stillness harmonizes with the stillness of the Breath of Life. From this fulcrum, the center of what's wrong, emerges the potency, the activity we might call healing. The unwinding begins as the life force emanates from the stillness of the fulcrum. The potency goes to work. Within moments, the previously still place of injury is full of vitality and is now moving with the surrounding tissues, all breathing together with primary respiration. That's what happens with in-person treatment, and that's what happens remotely, as well. It's a matter of following Dr. Still's admonition to use images of normal anatomy. That seeing can be applied remotely once you get beyond your disbelief that you are capable of doing it.

We can explain these phenomena—the Breath of Life and the beneficial effects of visualizing fulcra in the patient's energy—through principles of physics. First, we must recognize that in the center of what's wrong is where the health is.

Dr. Still's nephew, G. D. Hulett, DO, taught osteopathic principles at the American School of Osteopathy at the turn of the 20th century, when Dr. Still was still active at the school. Hulett wrote *A Text Book of the Principles of Osteopathy* in 1903 outlining what he taught. He said that function precedes structure. In fact, function creates structure. There is an energetic field somewhere out there that Hulett postulated to exist, which is responsible for the form necessary for that function to exist in material existence. It turns out that this idea expressed by Hulett and implicitly approved by Dr. Still was prophetic. For the Zero Point Field holds all information of the universe, including the function of a human organism, in virtual waveforms, accessible to the potency of the fluids. The fluids send in the instructions from the infinite library of the ZPF to meet the "plans and specifications" (Dr. Still) and correct this distortion of fascia. This is how healing happens in the flesh and can be directed from the energetic perspective equally well.

If you have a candidate on whom you would like to practice your skills, first obtain explicit permission from them to do this, then state their full name and relax/meditate with your mind open. Then state, "show me," and see what appears in your mind's eye. Show me what you would like help with, what you need, what is wrong. The image that appears now grows in refinement. At first it might look like a blob, but as you rest your attention on it without imposing or efforting, it begins to develop clarity. You might even state, "this is a rib," and see what response you receive. If there is a fluctuation of fluid, this is a "yes." If no fluctuation, this is a "no." Soon, you will be able to decide whether the rib is in inhalation or exhalation and whether its articulation with the sternum and vertebrae are dysfunctional, as well. Let the information continue to come in until you ascertain the direction in which the tissues are wanting to go. In your mind's eye, you take the tissues in that direction into balance. Better yet, you find the fulcrum for that distortion and place your attention there. Soon, the release occurs and a fluid dynamic courses through the formerly distorted tissue marking its return to health. This is just like treating with hands on.

If you want to try this with someone in the same room but without hands on, you will be able to get immediate feedback, but Zoom or FaceTime both work in that regard. In this time of physical separation from COVID, it might be the right time to experiment with connecting energetically. ◂

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Thinking Osteopathy with Will

Sutherland Memorial Lecture presented June 26, 2020, by Douglas E. Vick, DO

Introduction

Today, we are here to honor the osteopathic physician who developed the cranial concept in Osteopathy: William Garner Sutherland, DO, or Will, as he was known to his friends. I like to imagine that if he was here today, he would consider us his friends, so "Thinking Osteopathy with *Will*" is the title of this year's Sutherland Memorial Lecture.

William Garner Sutherland, DO, was a man whose achievements literally turned the world on its head, providing the medical profession with facts and ideas that were previously unknown. As a result of his life, millions, perhaps even billions, of lives around the world have been improved. What he managed to accomplish was nothing short of miraculous. But what is perhaps even more amazing, is that he accomplished all this by following *in the footsteps* of another giant in the medical profession, Dr. Andrew Taylor Still.

Come with me today as we explore an educational journey. This will be a true story, told in quotes, with commentary to fill in the gaps. The story is familiar to all of us, but this thoroughly referenced version takes a slightly different approach. In this story, we'll discover that Dr. Sutherland prepared us for success by leaving evidence in his teachings about an educational path that we can choose to travel in order to learn to "Think Osteopathy *with* Will."

Drs. Still and Sutherland

The Educational Path: Drs. Still & Sutherland

First Step: The Bones Themselves

All journeys begin with an initial step. What was the initial step on the path that Will took to begin his journey? And why did he take that step? Recalling that Will attended the American School of Osteopathy at a time when Dr. A.T. Still was actively teaching,[1, 2] it is likely that Dr. Still taught his students to follow the same path that he himself had taken. So what was Dr. Still's initial step?

In his *Autobiography*, Dr. Still wrote: "When I commenced this study I took the human bones and handled them, week in and week out, month in and month out, and never laid them down while I was awake for twelve months."[3] He held the human bones and became intimately acquainted with their every nuance. He stated, "I improved my store in anatomical knowledge until I was quite familiar with every bone in the human body."[4] He spent a year in constant contact with the bones, getting to know each one intimately, and this taught him to recognize the characteristic feel and features of each bone. This was important because it taught him to understand the normal[5]—what he should naturally expect with the palpation of each.

As he had learned from Dr. Still,[6] Will started his journey by examining the cranial bones. He said, "I found that anatomical texts, while describing the bones thoroughly as to shape, as well as to their external and internal surfaces, had very little to tell concerning the surfaces, which to the student of Osteopathy were the most important of all—the *articular surfaces*. To gain that knowledge, I began with the disarticulated bones"[7] by removing each bone from an intact skull to be able to see and handle each one.[8] He wanted to learn—as Dr. Still had before him—*all* of the features of each bone. Examining them from all sides and handling them over and over, he took the time to gradually develop the knowledge of the feel of each bone in his hands, and he could identify each bone's characteristics in intimate detail.[9] In this way, both men began their journey by developing a comprehensive knowledge of the features of the human bones and the feel of these bones in their hands.

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Second Step: The Articular Surfaces

Building on this general and kinesthetic awareness of the bones, their second step was a natural progression from their first step. Both men began to apply their extraordinarily detailed study of the articular surfaces, placing the bones together and carefully observing the way the bones naturally associated with one another.

Dr. Still said the goal of this study was to "know what the machine is, where all its parts are placed, their uses, supports, actions, relations—separately and united—the whole with its harmonious action."[10] As he continued his study and became increasingly more familiar with the articulations, he was able to visualize each joint in his mind. He explained, "By this extensive study I have formed in my head a perpetual image of every articulation in the framework of the human body."[11]

In a similar manner, Will examined the articular surfaces of each disarticulated cranial bone, paying close attention to the manner in which the articulations physically interacted with one another. He re-articulated the cranial bones over and over: as individual pairs, as groups of bones, and as a whole.[12] By doing this, he developed the ability to visualize the bones and their articulations in his mind, much as Dr. Still had done. Will found this ability to be a very important result of this educational step, later saying that, "The formation of a mental picture of the articular *surfaces* of the cranial and facial bones is the first necessity."[13] He believed that one must consider "the separate articular surfaces … as a whole in the mental picture of the cranial articular mechanism,"[14] feeling that the mental "picture should be like that of the watchmaker in his mechanical knowledge concerning the intricate works of a lady's small wristwatch."[15] "In my experience," he asserted, "this knowledge can be obtained only through diligent study of the articular *surfaces* as they exist on the separate bones of a *disarticulated* skull."[16]

Third Step: Motion

Having studied the bones with their articulations, placing these structures together as a complete unit, it was time to move on to the next logical step: to the motion of these joints. Dr. Still had believed that the body was a living machine,[17] and he taught his students that the articular surfaces have their characteristic architectural specifications in order to manage particular movements.[18] In other words, he taught his students to examine the structure in order to identify its function. He stressed that, "We must be critically certain that we know all articulations of the bones in the whole system"[19] in order to understand what the normal function is for those articulations.[20]

Although Will was attempting to disprove the idea that physiologic motion between the cranial bones could be possible,[21] his exploration of the minute details of the cranial articulations, and the faultless complexity of what he discovered, seems to have driven him on. He found himself pondering a myriad of questions[22] that were similar to the questioning style of his teacher, A.T. Still.[23] During this time, he may well have pondered: why did the articulations have the structural arrangements that were there? What function could require those arrangements? Why did the MasterArchitect design the articulations in these particular, unique ways?

What he found in his exploration was startling![24] As he observed the surfaces of the cranial articulations and as he associated them within his mind, Will was forced to accept that there was far more that indicated movement in the cranial bones than he had anticipated. Using deductive reasoning as his guide and a mechanical engineering text as a reference,[25] he discovered that, "Sutural arrangements display worm gears, cone gears, compensating gears, cryptic gears, friction gears and screw gears."[26] He could find "articular arrangements such as ball and socket, ball bearing, ball crank, box coupling, pit or pulley, counter shaft and even a cradle. Equalizing bars, escapements, flexible shafts, force pumps, governors, jiggers and the fulcrum"[27] could also be found. As Will's wife, Adah, said in her book, *With Thinking Fingers*, "Even the least mechanically-minded person would assume that various mechanical devices that display provisions for movement would work together to provide varieties of movement."[28]

How could this be? As he pondered the apparent dilemma, a familiar quote from Davis' *Applied Anatomy*, regarding the cranial base forming in cartilage while the vault forms in membrane with its sutures only starting to ossify in the fortieth year,[29] took on a new meaning—he realized that the necessary flexibility for movement at the sutures could actually exist.[30] His disarticulated specimens might be dry and inflexible, but the living human mechanism was not.[31] As he finally accepted the incontrovertible evidence for cranial bone motion, he realized that he would need to take the next logical step.

Fourth Step: Ligament(s)

From their detailed examination of the bones and the articulations, both men moved on to study the ligaments. Dr. Still said, "In my study I began with the bones. I associated them in their attachments by the adhesive ligaments, which bind the bones together."[32] He noted that "the two hundred bones … are all firmly fastened together with strong straps,"[33] and he learned "how to place them in their proper places for the discharge of their functions in life's machinery."[34]

However, this next step produced a challenge for Will: he couldn't find any ligaments across the cranial sutures. After intensive study and thought, he again used deductive reasoning to consider the foundational knowledge he'd obtained regarding the ligaments of the vertebral column,

continued

which "hold the spinal articulations together and also allow a certain range of movement at these joints,"[35] and found their parallel within the cranium, saying, "There is an interosseous membrane that holds the bones of the neurocranium together and allows a certain range of normal movement at the joints."[36] He recognized that the reduplications of the inner layer of the dura through the skull serve as the intracranial "check ligaments."[37] Then he delved further into his study of these structures to understand that "the three sickles on the inside of the cranium, specializations of the inner layer of the dura mater, constitute one structure that holds all the bones together."[38] Like Dr. Still, Will had discovered that the principle at work elsewhere in the body also held true with the articulations of the skull, and he declared, "I call this the *reciprocal tension membrane* of the human cranium. It allows a normal range of movement of the bones at the sutures."[39]

Fifth Step: Adnexa

After studying the bones and the ligaments, Dr. Still moved on to an in-depth study of what could be called the "adnexa," an historic term that means the associated anatomy.[40] He was quite inclusive in his exploration, stating that he "began with the bony framework; then took up its ligamentous attachments, its preparations for and the attachment of muscles; the organs, vessels and divisions that take part in constructing bones, muscle, ligament, membrane, [and] nerve."[41]

Will also continued with his exploration of the cranial articulations by considering their corresponding structures. He had previously studied the arteries and veins, nerves of all kinds, muscles, fascia and organs of the body, as Dr. Still had directed. In fact, as one of Will's early students, Rebecca Lippincott, DO, remarked, "Dr. Will traced the continuity of the fascia from head to foot."[42] Extending his study of the adnexa into the cranium, he stated, "My mission has been *applied anatomy*."[43] Will's knowledge of these related structures is clearly evident throughout his writings. His study of the central nervous system, in particular, led to the singular discovery that, "*All the physiological centers*, including that of respiration, are located within the floor of the fourth ventricle,"[44] and this information would have far-reaching consequences. He would later say, "*the artery remains supreme*, but the cerebrospinal fluid is considered to be *in command*."[45]

Sixth Step: Experimentation

There came a time when Will recognized that he had to take an essential next step. He had found, in his "study of the intricate articular surfaces on the cranial bones,"[46] that "every detail on those articular surfaces indicated mobility for a respiratory mechanism."[47] Now he had to know *how* these structures moved and functioned. "In the continued study," he said, "I eventually began experiments on my own skull."[48] Realizing that he had no other avenue for this exploration, he began to design and perform scientific experiments upon himself. "Why?" he asked, "because it was I who had to possess the personal knowledge."[49] In this way, Will confirmed the presence and movement of the reciprocal tension membrane, and learned about the fluctuation of the cerebrospinal fluid, the motility of the central nervous system, and the core-link connection between the sacrum and the cranium.[50]

I cannot publicly recommend doing his experiments upon ourselves, as they can be dangerous, but fortunately, thanks to Dr. Sutherland's teachings, we do have other avenues for exploration. For example, we can ask a trained colleague for osteopathic manipulative treatment and experience these sensations inside ourselves, obtaining knowledge via that route. Pursuing this is beneficial because, as Will explained, this kind of "personal knowledge is something that one must feel inside his own skull in order to understand the action"[51] of the primary respiratory mechanism. As a help to those who would come after him, Will suggested that, "The construction of a mental picture might help you in the recognition of the *feel* of the movement of the hemispheres. A way of doing this is to crawl inside the cranium mentally and assume a reserved seat on the foramen magnum and thus have a position for *visualizing* the activity as well as *feeling* it. One of the fundamental keys to diagnosis and technique is the ability to get within the cranium mentally and visualize all the activities going on."[52]

Seventh Step, and Final Step: Practice and Repeat

After extensive study and observation, the next step for both men was the careful application of their newfound knowledge to the treatment of their patients. Dr. Still said, "I determined to try my luck in the introduction of what I had proven to be a new discovery and a remedy for human ills."[53] Will began similarly. In her book, Adah tells us that "with the understanding that the procedures he was incorporating were still in the experimental stage he made use of cranial diagnosis and technics with a few patients."[54] Patients healed from the new treatments and referred other patients. It did not take long before Will found himself agreeing with Dr. Still, who had said "I soon found myself in possession of a large practice."[55, 56]

New patients brought in new varieties of complaints that required greater understanding.[57] Dr. Still had declared, "The more thoroughly we study and understand our anatomy and physiology the better we are prepared … and the more successful will be our work."[58] Will found that this was indeed the case, and that there was always more to learn and understand. So, like Dr. Still, Will's *final step* was one that took him through the remainder of his lifetime: repeating the prior steps of his educational journey over and over again as he traveled further along this path of knowledge about the living human body and as he moved on to teaching his students.

We've talked about the steps both Drs. Still and Sutherland took, and we've seen that we can elucidate and describe the

educational path from their footsteps. Keeping their focus on the MasterArchitect,[59, 60] they each paid attention to the realities of what they could physically see and feel, and then utilized deductive reasoning to ascertain the function of the structures in the living human body. They refined their palpatory acumen to a level that allowed them to verify and work with what they discovered, and then they treated their patients and taught their students. Now let's listen to one of Will's students as she describes that educational path from her perspective.

The Educational Journey: Will's Students

Their First Steps

Rebecca Lippincott, DO, and her husband Howard, were early students of Will's who became part of his early faculty. As Herb Miller, DO, said of them, "The Lippincotts were people that I learned more from than I could really express … and every meeting that Sutherland was alive and working, they were there."[61] In the 1940s, with Will's approval, they published *A Manual of Cranial Technique*, and Howard published *The Osteopathic Technique of Wm. G. Sutherland, DO*, which can be found as the Appendix in Will's book, *Teachings in the Science of Osteopathy* (together these are the original resources for Ligamentous Articular Strains and Balanced Ligamentous Tension (BLT),[62] and Membranous Articular Strains and Balanced Membranous Tension (BMT).[63] It is clearly evident from Dr. Sutherland's writings that he learned this Balanced Tension approach directly from Dr. Still.) The Lippincotts also helped Will compile and publish a booklet entitled, *Compression of the Condylar Parts of the Occiput*, in 1945.[64]

Rebecca presented a Sutherland Memorial Lecture in 1970. One thing I really love about Rebecca's writing style is that she takes us back to the time when she and her colleagues were first learning the cranial concept. She describes how "Dr. Will" taught them step-by-step, trying to bring them along in ten or so years what had taken him forty years to learn. In her Lecture, she wrote:

"In the beginning … he first described each bone of the skull in detail, pointing out its design for motion. He put them together and demonstrated their coordinated motion. Next he described the primary respiratory mechanism—the underlying principle of his concept. He pointed out the mechanics of the sphenobasilar symphysis, its positions, motion and restrictions of motion. He described the position and motion of each bone as the sphenobasilar symphysis moved into its four basic positions. He gave us the techniques for mobilizing each bone separately, and for the mechanism as a whole, all with balance and the respiratory cooperation of the patient. Traumatics were explained, techniques were demonstrated and practiced."[65]

With this brief description, Rebecca succinctly describes an educational journey that resembles the journeys which Drs. Still and Sutherland had traveled. Will's students studied the cranial bones and their articular surfaces in detail, just as their teacher had. Then they studied the bones' normal motions and mechanical physiology as they learned about the primary respiratory mechanism. Then they learned basic patterns that form the foundation for patient treatment, and finally they learned treatment approaches which they practiced on each other. However, Will did not intend for his students to end their journey there. Using this step-wise method, Will was making sure that their background of information became a secure foundation of knowledge upon which they could build as he continued to teach them what he had discovered.

Rebecca went on to write, "We studied and worked with this background of information until February 1945 when Dr. Will felt he had us ready for another step. Then he gave us the compression of the condylar parts of the occiput"[66] —his new booklet. Will was progressively adding to their understanding of the articular surfaces as he sequentially led them to further comprehension of his concept of the membranous-fluid nature of the primary respiratory mechanism. She reveals that it was "Not until the years 1947 and 1948 did Dr. Sutherland describe and explain [the technique of directing the potency of the cerebrospinal fluid] for the diagnosis and correction of cranial membranous articular strains or lesions."[67]

Their Next Steps

Continuing her Lecture, Rebecca entitled their next step on the journey: "The Fulcrum and the Cerebrospinal Fluid,"[68] explaining what Will had taught them next. She wrote:

"Dr. Sutherland described the fulcrum:

- as being in the region of the adjoining of the falx cerebri and the tentorium cerebella;
- as an automatic, suspended and shifting fulcrum which changes location as the stresses of the reciprocal tension membrane are altered by the lesion patterns and their releases;
- as responding to the respiratory cycle;
- as having 'fluid drive;'
- as being a relative 'still point' from which the reciprocal tension membrane and the cerebrospinal fluid fluctuations operate to attain an adjustment."[69]

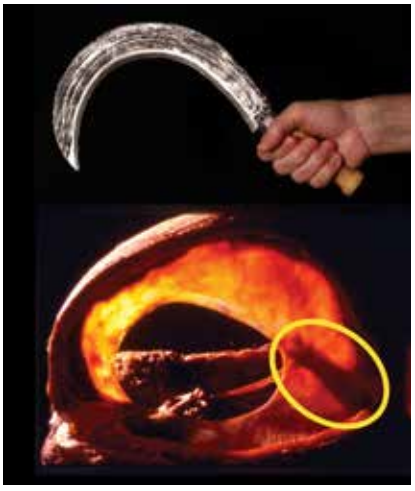
Let's pause Rebecca's description of the educational journey taken by Will's early students for a bit of applied anatomy instruction from Will himself. It might help us better understand what he was referring to as "the fulcrum"…

In a recording Will made the year before he passed on, he said, "The fulcrum in relation to the reciprocal tension membrane is a *still leverage* point **from which** the three sickles are suspended."[70] He clarified, "What do I mean by suspension? I do not mean that the fulcrum is suspended

continued

from its attachments. No. The fulcrum is at the point where the falx *adjoins* the 'tent.' Notice I didn't say *joins*. It is in between, in the area of the straight sinus."[71] He described the straight sinus as "passing through the automatic-shifting-suspension fulcrum."[72]

He elaborated, "This still leverage point is now described as the *suspension-automatic-shifting fulcrum*. It describes our view of the reciprocal tension membrane as being suspended **from** a shifting fulcrum located in the **center** of the skull and having attachment to the various osseous articular poles, instead of being suspended from the osseous articular poles and having attachment at the fulcrum."[73] Will was giving us an essential piece of information here to clarify his instruction. The junction of the falx and the tent functions as though it's the **origin** of the reciprocal tension membrane. It is similar to how the handle of this sickle that I am holding functions as the origin of the sickle, whether the sickle is vertical (like the falx) or horizontal (like the tent), with all the osseous attachments, including the sacrum,[74] responding to the motion and position of the fulcrum.



Sickle Handle and Sutherland Fulcrum

This can be a challenging concept for us to get, perhaps because, as we sit at the head of the patient's treatment table, we are looking down into the end of the straight sinus which is tiny in cross-section and is challenging to sense or see.

Treating and Finding Sutherland Fulcrum

However, a palpating finger-pad placed at the external occipital protuberance generally corresponds topographically to the approximate location of the confluence of sinuses, into which the straight sinus empties. From there, one can sense the straight sinus as it angles anterosuperiorly. Knowing this makes it easier to palpate the fulcrum, which was named "Sutherland's Fulcrum" by Harold I. Magoun, Sr., DO,[75] but Will himself, always humble, continues to refer to it simply as "the fulcrum" for the remainder of Rebecca's Sutherland Memorial Lecture, to which we now return …

Rebecca concludes her description of their educational journey by describing how Will further instructed them to cooperate with the primary respiratory mechanism in patient treatments. She wrote: "Dr. Sutherland placed more and more emphasis on the Intelligence and Potency of the cerebrospinal fluid in its use for cranial adjustments. According to this method of correction the cranial structures are placed upon delicate balance at the Sutherland Fulcrum, using the vault hold. Then our hands follow the changes in tension as the Intelligence of the cerebrospinal fluid directs the course of the adjustment and the Potency provides the motive power."[76]

Rebecca has us right there with her and her colleagues, listening to Will, as she continues: "He said, 'One feels this mechanism shifting when testing for motion. In reducing lesions the balance point is at the fulcrum. Learn to feel the position of the fulcrum. Use your thinking, feeling, seeing, knowing fingers by way of the vault contact to palpate the fluctuations of the cerebrospinal fluid. Let it go and you follow. Do not try to influence the Tide. It goes to restrictions and gives "little tugs." You will learn to feel the "drag" of the lesion. You can depend upon the cerebrospinal fluid to tell you the TRUTH and to do the work for you. Rely on the Tide."[77]

Then again she quotes him, saying, "Dr. Will said, 'Get the importance of the fulcrum point; it is not only a junction but a "still point" where we understand the importance of the cerebrospinal fluid highest element which henceforth shall be known as "liquid light."'"[78] Will is teaching us that Sutherland's Fulcrum is integral to the treatment process; remember he described the fulcrum "as being a relative 'still point' from which the reciprocal tension membrane and the cerebrospinal fluid fluctuations operate to attain an adjustment."[79] He said, "In the still point that arises from the application of these techniques, the motor is idling and there is an interchange between all the fluids of the body."[80]

In writing her Lecture, Rebecca said that she drew "generously on [her] notes taken from Dr. Sutherland, himself, as he presented his subject to class after class."[81] She succeeds in giving us a "glimpse" of Dr. Sutherland by reviewing the "sequence and progression of his teachings" and his "method of treatment."[82] She makes it easy for us to perceive the educational journey that Will led his early students along, as well as the similarities to the educational journeys that Will and Dr. Still had traveled.

The Educational Path: Our Future Steps ...

This path involves examining anatomy, all the anatomy, as thoroughly as possible, while contemplating the relevant mechanical physiology. It is a path that Dr. Still referred to when he spoke his famous phrase: "The osteopath must remember that his first lesson is anatomy, his last lesson is anatomy, and all his lessons are anatomy."[83] Some examples of this might include: examining the sutural anatomy—while contemplating the motions involved; examining the fluid cisterns—while contemplating the motions involved; examining the body's fascial envelope with all its reduplications—while contemplating the motions involved; etcetera, etcetera.

Does it matter where one steps onto this path? Does one need to travel along it in the order that Dr. Still, Dr. Sutherland and his faculty did? Maybe … maybe not. If we're going to follow in Will's footsteps, then we need to keep learning, to keep studying, to keep asking ourselves questions, such as "Why?" We especially need to keep studying those areas we find challenging such as sutural detail, fluid fluctuation and/or nervous system motility.

The Role of Mentors

Some of Will's students and their mentees were generous enough to allow me to learn with them at length, one-on-one, in a mentor-mentee relationship. They provided real-life examples of the success of traveling along Will's educational path … and they were all anatomists. At their home or in their office, they'd have anatomy books open and lying around, and their anatomical teaching specimens were readily available. We would discuss complex anatomy, and their treatments were obviously all-encompassing. When they treated, they did so with a fluid anatomical precision that was uncanny … because they knew their anatomy! They thoroughly educated me in the importance and relevance of the function of Sutherland's Fulcrum, demonstrating its application time and again. Let me introduce these osteopathic physicians.

My first mentor was an internal medicine specialist, Dave Vick, DO, who always had good hands and spent a year in Rollin Becker's office before becoming a full-time OMM professor at TCOM and then KCOM … some of you may have been taught by him. Growing up in his household taught me to Think Osteopathy. It was from him that I learned the 'touch' necessary to be a ten-fingered Osteopath.

After dad, each of my mentors was a lifetime member of the Board of Trustees of the Sutherland Cranial Teaching Foundation (SCTF). The SCTF was created by Dr. Sutherland to preserve and perpetuate his contributions to Dr. Still's Osteopathy. Rollin Becker, DO, a contemporary of the Lippincotts and then president of the SCTF for 17 years, was a man who spoke little, wrote much, and had hands that worked with the fluid more intelligently than anyone I have ever known, past or present. Watching him treat patients reminded me of the apparently effortless grace of Olympic athletes: his knowledge of the minute sutural and joint architecture combined with his vast knowledge of the connective tissues and central nervous system were so incredible, yet so comfortably ingrained, that his palpatory communication with the fluid fluctuation seemed effortless as he participated with the patient's mechanism to assist with their body bringing about amazing, spectacular, healing responses.

Rollin's knowledge of anatomy was unsurpassed. He taught me to sit at my own Sutherland's Fulcrum while I was treating patients, while being aware of their Sutherland's Fulcrum as well. His ability to allow the Intelligence within the patient's body interact with the Intelligence within his own was unequaled. It was from him that I learned how to truly "Listen,"[84] an art that could be better practiced by all of us.

Herb Miller, DO, was also a mentor. He had studied with Anna Slocum, DO, while attending the Des Moines Still College of Osteopathic Medicine and Surgery, and later practiced for several years in the office of Bill Rankin, Sr., DO. Both Anna and Bill Sr. were early students of Will's. Herb always referred to Bill Sr. as his mentor. In many ways, Herb was comparable to Rollin Becker, utilizing a very characteristic touch. If Rollin was king of fluid, then Herb was king of connective tissue, but he worked purposefully with the cerebrospinal fluid and central nervous system as well, although he rarely talked about them.

What Herb and Rollin taught me is actually best described in a paper Rollin wrote in 1983: "This constant, involuntary mobility demonstrated by the Sutherland fulcrum and its three sickles is reflected and palpable in all the connective tissues of the body and their enclosed elements—bones, muscles, organs, fluids, cells, etcetera … The reciprocal tension membrane is the working mobile tool through which trained palpatory skills can diagnose and work with these mechanisms within the patient."[85] Like Rollin, Herb would establish his palpatory contact anywhere on the patient's body, even down at their feet, and immediately connect with the patient's Sutherland's Fulcrum—it was phenomenal.

John Harakal, DO, professor and chair of the OMM Department at TCOM, and SCTF president for the 13 years following Rollin, was another mentor. Since he was Rollin's mentee, this kept it in the family. John was also best friends with Herb, and his treatments felt like a blending between Rollin and Herb. John taught me the art of distinguishing between the five phenomena. He was also a masterful educator who managed to teach me how to help others learn.

Here is Edna Lay, DO, at a course with Will. She was vice-president of the SCTF for about 30 years. She placed great

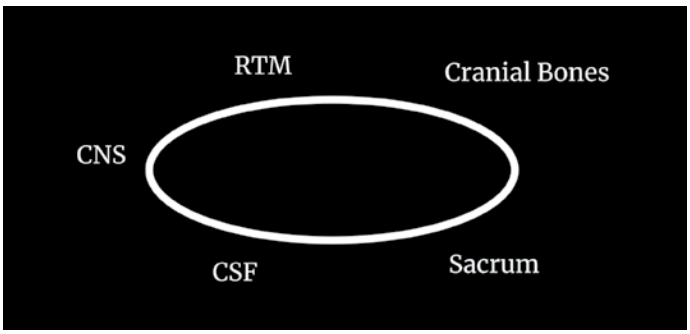
continued

emphasis on visualizing the anatomy between your hands during treatment. I paid a lot of attention to Edna, who did the bulk of the lecturing about the Face. She had always fascinated me with her teaching approach. She would get up there and lecture in such a way that I would be visualizing the living human anatomy as she spoke … it was fantastic!

Edna was the one I attempted to emulate when I began teaching about the Face. Sharing a common fascination for such an incredibly complex area of the body, we naturally fell into a friendly acquaintance. Over the years, as we spent more and more time together teaching, that grew into a mentor-mentee relationship. Eventually, we developed the SCTF Face course, which is devoted to providing the tools for understanding and palpating the complex anatomy and mechanical physiology of the living human face. She and I traded treatments a lot in her later years, and her treatments felt just like being treated by Anne Wales, DO, another contemporary of Rollin and the Lippincotts.

And Ed Miller, DO, has apparently deemed me a worthy student for the past several years. He has exceptional hands and a heart of gold, and is a veritable encyclopedia of knowledge. His innovative approach to the tongue has been a valuable addition to the Face course.

It is clearly evident to me that each of these mentors had, in one form or another, all journeyed along this educational path. They all shared a commonality that is consistent with Will's teachings. Although they each had their own unique touch during treatment, Sutherland's Fulcrum was integral in their treatments, and they all interacted with the primary respiratory mechanism as a unit of function, engaging and cooperating with all components of the primary respiratory mechanism during treatments.



PRM Is Unit of Function

Conclusion

In conclusion, let us ask ourselves the question, "Why?" Dr. Sutherland left us evidence of an educational path that he had learned from Dr. Still, an educational path which he himself had taken and which he then led his own students along. Will's students were able to learn this educational path and teach *their* students to follow it as they themselves had. Why? What was Will's purpose in leaving behind evidence of his journey?

During an introductory talk to participants at a cranial course 72 years ago in Des Moines, Iowa, Will referred to the following statement by Dr. Harry Chiles, "If one can **think** Osteopathy, one will **practice Osteopathy**."[86] It is clear that Will was allowing us, each and every one of us, to follow *in his footsteps*, learning as he learned, so that we could become better physicians. He wanted us to understand what he had learned so that we could treat as he treated, and care for patients and humanity in a more effective and efficient manner. He was preparing us to "*Think Osteopathy* with Will" so that we could "*Practice Osteopathy* with Will." Thank you, Will! ◂

Dr. Sutherland in classroom.

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