

The Cranial Letter

THE OSTEOPATHIC CRANIAL ACADEMY, INC.



A Component Society of the American Academy of Osteopathy

Quarter 3 | 2026



Inside

- President's Message
- 2026 Annual Conference Highlights
- Paul Dart, MD, FCA Sutherland Memorial Lecturer
- 2027 Annual Conference Invitation
- Upcoming OCA Events



The Cranial Letter

The Official Newsletter of
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Quarter 3 2026

Contents

President's Message	3
Julie Mai, DO, OCA President	
2026 Annual Conference Highlights	5
Sutherland Memorial Lecturer: Paul Dart, MD, FCA	13
2027 Annual Conference Invitation	27
Scientific/Technical	29
Cranial Articular Surfaces; Facial Area "The Mandible"	
Call for Papers	30
OCA Print/Media Resources	30
OCA Upcoming Events	32

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

President's Message



Julie Mai, DO

Dear OCA Members,

I hope the start of your summer is filled with warm sunny days as you anticipate future travel adventures and events with loved ones.

OCA kicked off June with our 2026 Annual Conference, “Development of Cranium and Face: Newborn to Adulthood”. It was an exceptional educational program led by our Annual Conference Director, Tasha Turzo DO FCA, and her outstanding line up of speakers. In addition to enriching knowledge on orofacial development, the faculty highlighted the wonderful collaboration between osteopathic physicians and dentists.

A special thank you to the Osteopathic Cranial Academy Foundation for the generous grant that supported many of our attendees.

The OCA also held our first-ever mentor event on Friday evening: “Hand to Hand Tradition: OCF Mentorship Evening”. Special thanks to the twelve generous mentor volunteers (listed under 2026 Annual Conference Highlights) who made a meaningful impact for those in attendance. We look forward to continuing this tradition to foster the next generation of osteopathic physicians. We also hosted a wonderful Wine & Appetizer Social Event in my Presidential suite. It was a relaxing opportunity to connect with new and familiar colleagues.

Please join me in congratulating our newly elected Board members: Larry Barnard DO and Melissa Pearce DO. The OCA extends a deep gratitude to our outgoing Board members: Jay Danto DO and David Spencer DO.

Mark your calendars for the 2027 OCA Annual Conference, “Communicating with the Living Digestive System” directed by William Foley DO, from June 17-20, 2027, at the Westin Hotel in Indianapolis, Indiana. Registration opens in late Fall on the OCA website. We look forward to seeing you there!

Our Fall Hybrid 40-hour Introductory Cranial Course directed by Elena Timoshkin DO, is filling quickly and will be held in three locations: California, Texas, and Kentucky. Notably, the majority of participants are osteopathic medical students taking their first 40-hour Introductory Cranial Course. The OCA offers the Hybrid Introductory Cranial Course twice a year. The next Introductory Cranial course is scheduled for March 2027 at the AAO Pre-Convocation in Dallas, Texas. OCA Foundation provides 100% Tuition Assistance for qualified medical students while there is funding available, and 50% Tuition Assistance for students, residents and doctors with 10 years or less of practice.

In addition, our intermediate Cranial Base Course directed by Jose Camacho DO will take place in Portland, Oregon September 24-27, 2026, with a stellar group of faculty. This course will build your palpatory confidence with precision techniques to engage intraosseous, articular, fluid, membranous, and ligamentous restrictions in the cranium, cervical, and sacral areas.

President's Message

At the Annual Membership Meeting, I provided an update on the significant progress the OCA Board of Directors made this past year in strengthening financial oversight, governance, and operational structure. We were aware that Financial Reviews for 2021–2024 had not been completed as required by our Bylaws. We addressed this by completing the outstanding 990 tax filings and engaging an independent financial firm, Optima, in early 2025 to clean up bookkeeping errors in QuickBooks and investigate prior discrepancies. All four years of Financial Reviews were completed by the end of 2025.

This led to two key structural improvements effective July 2025:

- Transitioning financial management to a dedicated independent bookkeeping firm, which allows our Executive Director and Management Company to focus on CME events and mission priorities.
- Implementing a formal policy for clear oversight of payments and reimbursements.

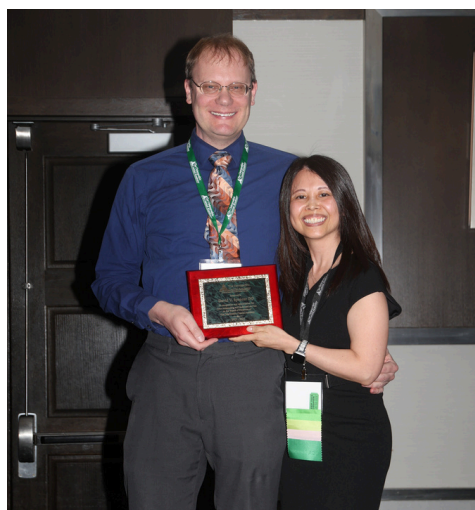
With records now accurate, we completed the 2025 Financial Review and filed our 2025 990 on time by May 15 with guidance from our tax accountant. We are committed to maintaining this standard going forward. The OCA remains in good financial standing with the IRS and State of Indiana.

We also welcomed a new Executive Director, Amanda Bureau, who is part of our new management team, Oak Ridge Association Management Company. Oak Ridge's deep expertise in the osteopathic community, AOA accreditation, and CME standards will help advance our mission.

These changes have brought greater financial oversight, accountability, and long-term strength to the OCA. There is a renewed confidence in the organization resulting in a membership growth of 37% since last year that consisted of both returning and new members. I would like to convey my heartfelt gratitude to the many members who personally approached me after the Annual Membership Meeting presentation to express their appreciation for these positive forward changes. Thank you for your continued support and belief in our profession.

Serving in Gratitude,

Julie Mai DO
OCA President



Outgoing Board members: Jay Danto DO and David Spencer DO were recognized for their leadership service.

2026 Annual Conference Highlights

Development of Cranium and Face: Newborn to Adulthood

June 4-7, 2026 | Hyatt Regency Indianapolis, IN

OCA's 2026 Annual Conference was a wonderful time of connection and learning. The Conference explored the anatomical structures and functional systems that shape the human face across the lifespan. We examined how these functions influence dental occlusion, cranial motion, and overall craniofacial harmony. Attendees also reviewed the embryologic forces that drive growth and development from newborn through adulthood, gaining a deeper understanding of the dynamic changes that occur throughout each phase of life.

A new element was introduced at this conference: "Hand to Hand Tradition: OCF Mentorship Evening," a relaxed, small group gathering created to support the sharing of knowledge and experience from one generation of osteopathic physicians to the next. Attendees had the opportunity to listen, ask questions, and build meaningful connections with some of the most experienced mentors in our field.

The OCA Foundation generously provided a grant to support attendance of students, residents, and early-career physicians.



OCA is grateful for the many experts who contributed their knowledge and talent to the program.

2026 Conference Faculty

Tasha Turzo, DO, FCA – Conference Director
 Josh Krembs, DO – Assistant Conference Director
 Paul Dart, MD, FCA – Sutherland Memorial Lecturer
 Allison Adams, DMD
 Elliott Blackman, DO, FCA
 Alex Bronson, DMD
 James Bronson, DDS
 Stefan Hagopian, DO, FAAO
 Traci Jones, DO
 Steve Kisiel, DO
 Julie Mai, DO

Mentors for Hand to Hand Tradition: OCF Mentorship Evening

Lawrence Bellew, DO
 Maria Coffman, DO
 Paul Dart, MD, FCA
 Stephen Davidson, DO, FCA
 Richard Feely, DO, FAAO, FCA
 William Foley, DO, MSc
 Andrew Goldman, DO, FCA
 Stefan Hagopian, DO, FAAO
 T. Reid Kavieff, DO
 Hollis King, DO, FAAO, FCA
 Harold Kornylak, DO
 Chris Stephenson, DO

Thanks to our talented members for contributing photographs from the Annual Conference. The pictures on the following pages were provided by Arlene Dijamco, MD, Julie Mai, DO, and David Spencer, DO.

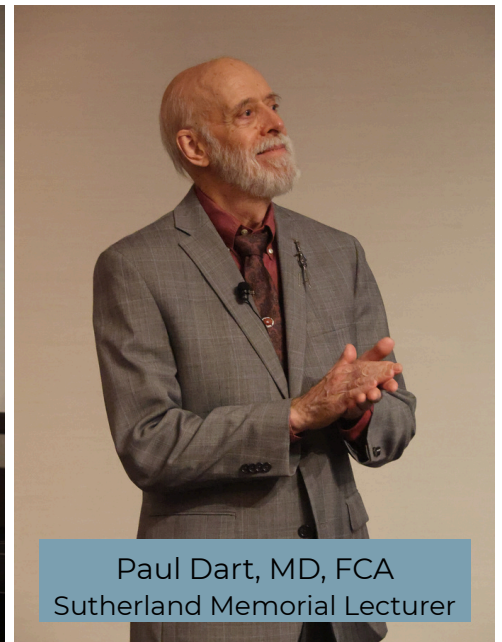
ANNUAL CONFERENCE



Tasha Turzo, DO, FCA
Conference Director



Josh Krembs, DO
Asst. Conference Director



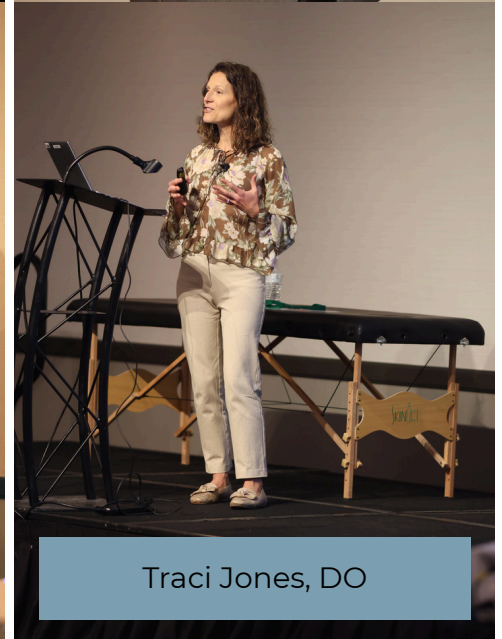
Paul Dart, MD, FCA
Sutherland Memorial Lecturer



Allison Adams, DMD



Steve Kisiel, DO



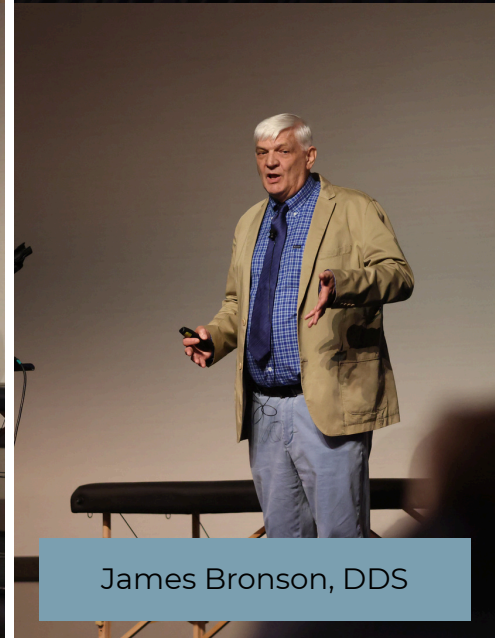
Traci Jones, DO



Stefan Hagopian, DO, FAAO



Alex Bronson, DMD



James Bronson, DDS

ANNUAL CONFERENCE



Paul Dart, MD, FCA receives the Sutherland Memorial Lecturer pin from Therese Scott, DO, FCA



Conference Faculty Panel



OCA President Julie Mai, DO and AAO President Sheldon Yao, DO, FAAO



2026 Conference Director Tasha Turzo, DO, FCA passes the torch to 2027 Conference Director Bill Foley, DO, MSc.



OCA Foundation Donors who contributed \$1,000 or more.



First time attendees received a copy of *A Manual of Cranial Technique*.

ANNUAL CONFERENCE

There was much to learn from peers during the labs and the new program, Hand to Hand Tradition: OCF Mentorship Evening.



ANNUAL CONFERENCE



ANNUAL CONFERENCE



ANNUAL CONFERENCE

Attendees enjoyed socializing and dancing during the Recognition Banquet.



ANNUAL CONFERENCE



Digging On

Paul Dart, MD, FCA was honored as the 2026 Sutherland Memorial Lecturer. The following is a transcript of his lecture and lab, which was presented at the 2026 Annual Conference.

PART 1

Thank you. I deeply appreciate the opportunity to talk to you today.

Who am I? I am an MD and a GP. I was trained at Mayo Medical School, in Rochester, Minnesota, and did an internship in the Family Medicine residency at Oregon Health Sciences University. According to the Glossary of Osteopathic Terminology, I am not an osteopath – I am an osteopathic practitioner. I'm a solo practitioner, working out of a home office. In the 1980's, starting out as an MD practicing OMM, I had to be a solo practitioner. I wasn't going to be doing OMM in an allopathic group practice. Being a solo practitioner left me free to do what I wanted in my office. And I could close my office to go and study whatever I wanted, whenever I wanted. I believe I was the second MD member of the OCA. When I arrived on the scene in 1988, people would look at my name tag and say "You are an MD! What are you doing here?" The short answer was "Just like you...once I found out about it, I couldn't stay away."

How did I get here? My father was a missionary brat who grew up in Angola. As a young man, he became a physicist. He also became a quaker mystic. He did not find a contradiction between the divine and the scientific. In the late 1950's he became deeply involved with cross-cultural education in the sciences. So, my first two years of elementary school were in a two-room schoolhouse in Katmandu, Nepal.

At that point in time, most people in Nepal were living essentially as they had been living since the Middle Ages. Living in Nepal gave me an early recognition of the fact that our perspectives are shaped by our culture – and that there

are many ways to think about and be in the world. In 1963, my father published an article in *Foreign Affairs* titled "The Rub of Cultures." This article discussed his experiences with education in Nepal and the challenges of teaching modern science (a part of "western" culture) in another cultural setting. This paper was quite influential because it touched on issues about foreign aid that had not really received discussion before. When I was a senior in high school, my father gave me a copy of Thomas Kuhn's book *The Structure of Scientific Revolutions*. It was Kuhn who coined the terms "paradigm" and "paradigm shift" in discussions of the history of science. Reading this book helped me understand a lot about what science was, and what it was not. This was very useful to me later in college, as I became more involved in the study of the social and physical sciences.

The thrill of victory! In 1969 I entered college at the University of California, Santa Cruz (UCSC), where I studied psychology and anthropology. But I really spent the majority of my efforts doing peer counseling and learning to be a competitive fencer. In learning how to fence, I learned how to learn. Fencing is an art form, and in learning any art form, progress is not smooth. You have to practice things quite mechanically for a while, and master the mechanics, before you can achieve a state of grace or intuitive flow. As you progress, you get better at things for a while. Then you hit a plateau, where you stop improving. And then, you start to get worse at it! Because for your skills to advance further, your learned habits must disintegrate, in order to reintegrate at a higher level. This being stuck on the plateau and then falling OFF the plateau happens repeatedly as you learn an art. And it is a horrible experience! Many people abandon their efforts after falling off the plateau. It takes a good teacher to keep the student interested and engaged through this repeated process. And I had a very good teacher. When I was a senior, he took me aside and said: "Paul, you are an excellent fencer now, and in becoming one, you have learned how to learn, and what the process of achieving excellence requires. This means that you can learn anything." Later on, when I returned to college for premedical studies in my late 20's, it turned out that this was the case.



SUTHERLAND MEMORIAL LECTURE

After graduating from UCSC in 1973, I rattled around for a bit: fencing bum and unlicensed hippie carpenter's apprentice in Oakland, California; desk clerk in an apartment hotel in Honolulu, Hawaii; self employed teaching cocounseling and fencing in Eugene, Oregon. Then two things happened that radically changed my life. My father died of a brain tumor at the age of 63. And I got a knee injury that turned into chronic chondromalacia patella, which made it quite difficult and frustrating to continue to teach fencing. I decided that I wanted to learn more about the mind/body connection, about why people get sick, and how to support the healing process. The doctors I knew were not asking these questions. So I naively decided to become a doctor myself and learn enough to find my own answers. This meant that I had to go back to college and study the basic sciences.

I was 27 years old, and my friends thought this was kind of nuts. They said: "You do premed for two years, then four years of medical school, then an internship, that's seven years. Even if you don't do a residency, by the time you are done, you'll be 34 years old! This was true. But when I thought it over, I realized that if I DIDN'T go to medical school, and spent the next 7 years goofing around, fornicating and snorting cocaine, at the end of it all I would STILL be 34 years old! So, I moved to Seattle to do my premedical studies as a post-baccalaureate at the University of Washington. And then I moved to Rochester, Minnesota, to go to medical school at the Mayo Clinic.

When I started medical school in 1980, life got more stressful. They were building the trident submarine fleet, and some government officials were talking as if we could WIN a nuclear war. My first autopsy was a newborn baby, and I had to leave the room several times to keep from fainting, as I watched them cut it into pieces. All this really shook me up. I started to think: "Great, I'll go through all this stress and traumatic effort for four or five years. Then they'll have a nuclear war and we'll all die." It really did seem like a 50/50 proposition. But one of my best teachers had told me that when you are faced with a difficult choice of actions and can't intellectually decide which is the more likely to succeed, the best thing to do is to choose the path which, if it did work out, would produce a more interesting result. I decided that it would be more interesting if the future actually existed. So, I chose to believe that and acted accordingly. So far, this has worked out well for me.

Right here in the present, we can always ask ourselves: Is the world that we perceive real, or are we just dreaming it? Is it possible to know for sure? Philosophers have debated this question for millennia. But I choose to believe that reality exists. I think that it is the more interesting option. This same question comes up as we are learning osteopathic perception. As we tune into subtle perception, even subtler realms start to reveal themselves. The question can arise – is this perception real, or am I just imagining it? Another of my early teachers helped me with this by asking me: "Well, if it is a real perception, what would you say that you are perceiving right now?" I find it most useful to act as if my perceptions are real and proceed from that assumption.

Watching our elders at work can be kind of intimidating. They perceive such subtlety, so quickly. At the first OMM course I ever took, Paul Kimberley put his hands on a student's parietal bones for 2 seconds – and then he said, "that left palatine is stuck." I asked myself: "Who is this wizard?" As I continued to learn, I came to understand that my elders weren't magicians. It's just that they'd spent a lifetime tuning in to more and more subtle levels of perception. In my work I now perceive things that I would not have thought it possible to perceive 20 years ago. Sometime around 2008, I stopped being willing to have assumptions about what would be impossible to perceive. I had to let go of that. I certainly have limits to my perception. But I've come to see that these limits are not necessarily limits in my potential ability. Rather, they are created by the boundaries of my comfort zone.

Does it work? I confirm my new perceptions by the response of my patients. I observe, then I act on those observations. And then I await the results. Does something change in the patient's condition? Does something change that I could not change before? Learning this way has been a fascinating adventure. But even when my work goes outside the norm, I don't think of it as unscientific.



Robert Fulford DO

What is science? Essentially, science is the study of the unknown. The study of the known is called engineering. We physicians like to think that we are practicing in a scientific profession, but most of the time we are working like engineers. After all, we are expected to know what we are doing, and we hope to get predictable results. Of course, medical practice is also an art. Sometimes science contributes new ideas that are integrated into medical practice. This can take a long time, and frequently the knowledge that we apply in our medical practice is about 20 years behind the cutting edge of scientific knowledge. Sometimes clinical observations found in the art of medical practice produce new concepts, that are later explained scientifically. This can also take a long time. In 1847 in Vienna, Austria, Ignaz Semmelweiss discovered that if he washed his hands in a solution of chlorinated lime before delivering babies in the hospital clinic, he could reduce the risk of maternal death from 95% to 23%. This was before the discovery of bacteria. At that time doctors in hospitals were doing autopsies of women who had died of what they called puerperal fever and we call sepsis, and then immediately doing manual exams of women in labor on the same ward. Semmelweiss shared his approach with his colleagues, but he couldn't explain why it worked, and finally they drove him out of town.

Late in 1860, in France, Louis Pasteur demonstrated the existence of bacteria.

In 1865, Joseph Lister combined these two concepts in his clinic in Glasgow, Scotland, and (re)invented antisepsis. Based on Pasteur's work, Lister could explain the mechanism of his procedure's effects so in time his ideas were more broadly accepted. This launched a period of tremendous progress in thoracic and abdominal surgery. Scientific discovery starts with observation and perception. Then relationships are induced from these perceptions. Then deductive reasoning is used to evaluate possible consequences of these relationships. Experiments can then be designed to confirm and more precisely quantify these relationships and their consequences.

This is exactly what we are doing in osteopathic practice. We use our perception to make diagnostic observations of the inner and outer world of our patient, to guide the use of interventions in altering the world of our patients, and to judge the results of these actions. The unique aspects of osteopathic medical practice are grounded in the osteopathic physical examination. I want to emphasize the fact that these perceptions of the patient are objective information. In the SOAP chart note format, the Subjective part is the history. The Objective part is the physical exam. After completing these two activities, a physician uses their knowledge and experience to perform an Assessment, which is (at least provisionally) a diagnosis. And then they come up with a Plan, for further testing if needed to confirm and refine the diagnosis, and for medical and/or surgical treatment of the problem. In medical practice, the initial objective observations are obtained by physical examination. This has been the practice of medicine for 2,500 years.

Perception isn't perfect. That's why we look both ways before crossing the street. And now that I'm over 60, I look both ways twice. But perception can be objective even if it isn't consistent. When you only see the car the second time you look, the car was always there. When the bird stops singing, it is still present in the forest. Water runs downhill. You can have an objective experience without being able to explain it. Newton saw the apple fall, but he couldn't explain how gravity worked. His observations still had scientific value. Semmelweiss couldn't explain why washing his hands worked like it did. But he still reduced the death rate in his patients by 70%. Don't mix up objectivity with the ability to explain "why." Measurement isn't explanation. Measurement can refine our perception of events. Consistency in measurement can confirm a deduction. But measurement alone cannot explain "why" something happens. Precise measurement can validate a hypothesis. Without the hypothesis, measurement by itself does not explain anything.

With our physical examination, we observe the world. When you observe the world, you may encounter phenomena that you can't explain. This doesn't mean that they aren't real. This means that you are involved with the first half of science – observation and inductive reasoning.

Our elders were not shy. Our elders talked a lot about things that were hard to perceive and even harder to explain.

Andrew Taylor Still:

"Life is that force sent forth by the Mind of the universe to move all nature."

"Man is triune: First, the material body; second, the spiritual being; third, a being of mind which is far superior to all vital motions and material forms, whose duty is to wisely manage this great engine of life."

Image: Andrew Taylor Still, c. 1914



William Garner Sutherland:

"... we are directing not only a potency, but a potency that has intelligence within it--a body of fluid that has the Breath of Life, that has 'something' invisible, not only of potency but an Intelligence spelled with a capital 'I.'"

Lab 1 – Is the world breathing?

Human perception is a very subtle instrument. Place one hand on table, the other hand holding your partner's hand. Which is alive? Well, yes, it is pretty obvious which is alive. But how do you "know" this, why is it so obvious? OK. The table isn't alive. But this doesn't mean it can't move. Just palpate the table now, both hands on the table. Is the table moving right now? Very slowly shrinking or expanding? If you can't say with confidence that you feel it moving, what happens if you imagine it is moving? If you imagine this, right now, is the table shrinking or expanding?

Viola Frymann:

"This etheric body is the electricity, or energy, that keeps the physical body operating."

Rollin Becker:

"An operator is necessary, yes, in this electrical universe, but he should know and use 'the mysterious forces that create the tide' to do the work in treating each case. Therefore, let us call this mysterious force the Breath of Life and hold a true course towards it."

Robert Fulford:

"A bioenergetic field exists around the body, maintaining the balance and total functioning of the physical form."

Paula Eschtruth, DO:

"Watch the energy, hold the energy, let it do the work."

"I just take out the bad energy and put in the good energy."

PART 2

When I was young, around 80% of physicians were self-employed. Now, around 80% work for corporate medicine. What drives corporate medicine? Is it logic? Is it ethics? Is it science? No. It is money.

As you may see, money can confuse the picture. For example, the AMA makes big money from controlling and publishing CPT and ICD coding. Coding has to do with billing for reimbursement. Coding determines what treatments get paid for. If you can't code a diagnosis, you can't bill for treating it. There is no ICD10 code for multiple chemical sensitivities syndrome. Or for EHS/microwave syndrome. Or for chronic adrenal fatigue. These are diagnoses that the institutions that pay for disability insurance or for liability insurance do not want to have to pay for. No code, no billing, no payment.

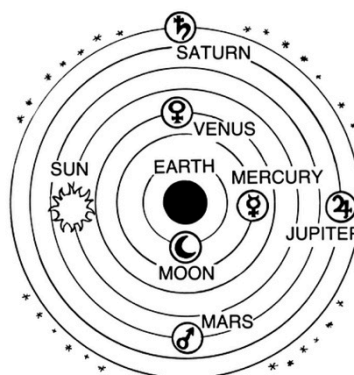
If you were an anthropologist from Mars who came here to study us, you would think that science is the religion of our culture, and doctors are the high priests. We talk about "orthodox" medicine. The word orthodox is a religious term. So is the word unorthodox. And radical controversies in medicine can be handled with all the rationality and subtlety of the Spanish inquisition. Being too unorthodox makes you a medical heretic. This is religious behavior. Orthodox medicine vigorously defends its financial and cultural interests. Orthodox medicine attacks its foes by accusing them of being "unscientific." Orthodox medicine requires doctors to obtain CME credits. Orthodox medicine requires CME offerings to be "scientific." Or, more precisely, to not be "unscientific."

When I was in medical school in the early 1980's, they estimated that it took 10 million dollars to prove that a new drug was safe and effective. The drug company recoups their cost by patenting the drug, which gives them a monopoly for long enough to make a profit. No one was going to spend \$10 million dollars to validate the use of a vitamin or dietary intervention – because they can't patent those treatments. And this absence of research allowed orthodox medicine to say that such treatments were "unproven" and that their promotion and use was "unscientific." The word "unscientific" is not usually a word that is used as an adjective by research scientists, when they are describing natural events in the world. But when it is used, it is often applied to observations or ideas that haven't been thoroughly explained within the current scientific paradigm. In medicine, however, "unscientific" is usually used as a pejorative term. It is used by people who want to put someone else down. Or discredit them. Or

avoid paying for their services. Whether effective or not, any clinical practice that is deemed to be too far outside mainstream can certainly be subject to this sort of attack.

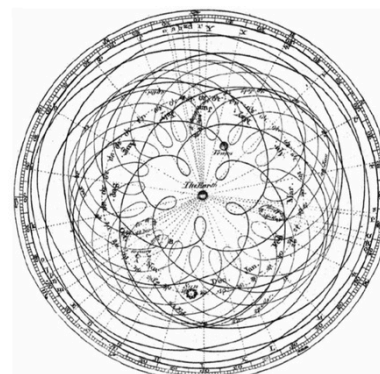
What is "normal science"? Does attacking novel ideas in this way make sense? Why does it happen so frequently? To understand the implications of the term "unscientific," we need to take a deeper look at what science actually is, what it does – and what it does not do. This leads us to a deeper discussion of Dr. Kuhn's seminal work.

Ptolemy's universe Normal science operates within a paradigm or model of the discipline that is accepted by consensus within that scientific community. For example, for 14 centuries the study of astronomy operated within the paradigm defined by Ptolemy in 150 CE. This paradigm placed the earth at the center of the orbit of all other heavenly bodies in the universe. Throughout that time, scientific activity in astronomy was focused on refining and articulating the details of this paradigm.



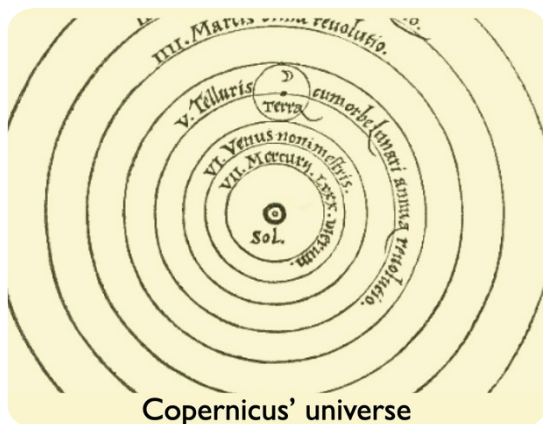
Ptolemy's universe

Over time, astronomers quantified the accepted qualities of the model more precisely, creating more complex mathematical models of the "orbits" of everything around the earth, in a continued effort to resolve any apparent contradictions in the data. But the more they refined the model, the more obvious and problematic these contradictions became.



SUTHERLAND MEMORIAL LECTURE

Only after their efforts repeatedly failed to resolve these remaining problems, did an alternative paradigm receive serious consideration.



The Large Hadron Collider

The paradigm provides a context for rules and expectations that define normal (or normative) scientific research – including the accepted boundaries of that research. This context and these boundaries are a necessary prerequisite to the huge investments in time, effort, and financial capital necessary to perform this work. And this focus on working within the paradigm allows science to progress more rapidly. This is the effort and focus that produces a level of detailed and precise understanding that can be used in engineering. Most “normal science” is fact-gathering. Normal scientists devote all their efforts to refining the knowledge within the existing paradigm. These activities involve:

- Work to quantitatively refine facts that the paradigm shows to be particularly significant.
- Work to establish facts that can be compared directly with predictions from the theory.
- Work to resolve residual ambiguities, define physical constants, refine quantitative laws, and explore technical applications of the paradigm.

As an example: If the paradigm says the world is a sandbox, then research will involve studying the contents of the sandbox in all possible detail. This research must be performed with methods that the scientific community considers to be appropriate for that use (e.g. toy shovel, toy bucket, toy dump truck, measuring cup, kitchen scales). If one is to search for water deep in the sandbox, one could do so with the shovel and the bucket. These would be accepted tools in the sandbox research community.

But using a hazel wand to dowsing for water in the sandbox would not be considered an appropriate or valid approach,

even if one found water as a result of that effort. Because dowsing is not a validated tool within the sandbox paradigm. And if a unicorn with magical healing powers comes by and sits down in the yard, it will be ignored by the researchers – because it is not in the sandbox. They are studying the sandbox.

“Normal” science is puzzle solving. But scientists won't choose to work on puzzles that don't appear to be solvable with the tools and concepts at their disposal. And for a puzzle solution to be accepted by the conventional scientific community, it must fit into and/or confirm the conventional paradigm. Solutions and methodologies that contradict or step outside the world view imposed or supported by the paradigm will not be acceptable. Normal science is not interested in working outside of the sandbox. Nor will science's economic ecosystem be interested in investing the resources necessary to test puzzles that are outside the sandbox.

Thomas Kuhn:

"No part of the aim of normal science is to call forth new sorts of phenomena; indeed those that will not fit in the box are often not seen at all . . . Normal science does not aim at novelties of fact or theory and, when successful, finds none."

In general, problems that cannot be explained or tested within the paradigm will not be considered worthy of exploration.

The Emergence of Anomalies

An anomaly is a new and unsuspected finding that does not fit within the paradigm. Perhaps a finding that contradicts the expectations produced by the paradigm. Perhaps a finding that cannot be explained by the paradigm. As the paradigm model is filled out more precisely by continued research, evidence of the parts of the world that don't fit within the paradigm starts to show up more frequently. And the more precise the model gets, the more difficult it becomes to dismiss these anomalies simply as errors or noise in the data collection process.

But normal science has strong resistance to stepping outside of the paradigm. As long as solutions can be found using its approved tools and methods, working within the paradigm is the quickest path to scientific progress. Even if anomalies are recognized, every effort will be made to explain them by refinement of technical and theoretical applications within the current paradigm. For example,

Ptolemaic astronomers spent centuries using more and more complex mathematics to try to make the motions of the heavenly bodies fit into the Earth-centric model.

Crisis

If work within the paradigm continues to solve important problems, and anomalies that emerge seem peripheral to those problems, then those anomalies will probably be ignored. The circumstance must be quite significant to turn an anomaly from just another peripheral puzzle into a big enough deal that it starts to interrupt the "business as usual" of normal science. The significance of such an anomaly must be widely accepted before it can produce a crisis of faith within the scientific community. So, if most anomalies are ignored, what sort of anomaly might produce a crisis?

- One that clearly contradicts some fundamental principle of the paradigm.
- One that suggests a path to solution of a major problem which extensive work within the paradigm has failed to solve.
- Or one that is made significantly more obvious by new developments within normal science.

Response to Crisis

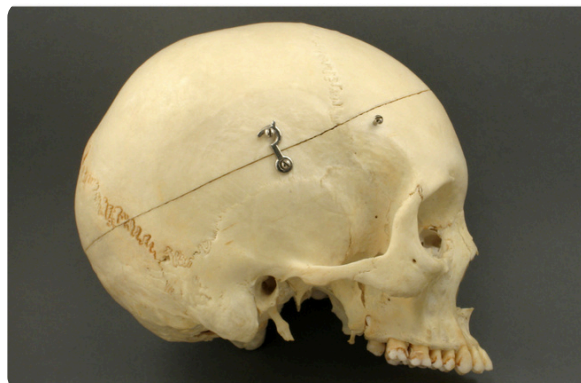
Initially, efforts to resolve this crisis will work within the paradigm. But these efforts will start to diverge in more and more different directions. The boundaries of the paradigm will begin to blur, and even some previously accepted solutions will be questioned.

Finally, someone comes up with a new theoretical model that seems to propose a solution to the problem. (This is often someone younger, whose career isn't so deeply invested in the current paradigm.) This new model will explain some things that haven't been explained before and explain some other things differently than they have been explained before. If this new model or paradigm gains enough acceptance within the scientific community to replace the old paradigm, then we can say that a scientific revolution has occurred.

Scientific revolutions are changes of worldview. It isn't easy to change a worldview. This sort of change can produce culture shock.

Studying science in detail, and assimilating a paradigm, does change how you see the world. Water's behavior looks different after you understand its molecular structure.

Changing paradigms also changes how you see the world. Allopathic physicians look at this picture and see lines of fusion in a skull. Osteopaths see moving surfaces, shaped by the function of primary respiration. If the patient has migraine headache: allopaths see vasospasm. Osteopaths might see temporosphenoidal compression at the sphenosquamous pivot.



I remember taking my first course with Dr. Fulford. I learned to perceive the void of energy inside the area of restricted motion. I learned how to feel the energy activity of the mechanism in the restriction, as the treatment process unfolded. This was a different sensation than fascial shifting from one position of balance to the next. Attending to it during treatment seemed to make the treatment deeper and more efficient. I went home and started trying out this new approach with my patients. Three weeks later I came into the office after a difficult weekend at home, somewhat sleep deprived. In my foggy state it was so hard to feel this subtle new perception. I thought: "I can't work in this new way today. I need to go back and do it the way I was doing it before." But when I tried, I couldn't remember how I had done it before! So, I had to keep using the new approach anyway, even though I felt too stupid to do so.

The change of perspective that is brought about by a paradigm shift can be difficult if not impossible to reverse. It becomes very difficult to see the world both ways at once. Historically, this change of perspective often occurs as a flash of insight, sometimes during sleep. It is not usually the result of repetitive analysis of the same data that is explained by the pre-existing paradigm. We think of Archimedes in his bathtub, suddenly realizing how to weigh a ship. We think of AT Still's youthful experience of hanging his head on a swing and having the first insight that started him on the path to developing osteopathy. We think of Dr. Sutherland looking at a disarticulated temporal bone and thinking that it was "beveled like the gills of a fish, indicating respiratory motion for an articular mechanism." For a scientific revolution to occur, the practitioners of the science must experience this change of perspective. But this not something that the practice of normal science prepares them to easily do. Normal science is not about

testing paradigms Normal scientific activity is not about challenging or testing the scientist's world view. It all is performed within the world view of the scientist. Normal scientific research is not about testing the paradigm. It is puzzle solving within the boundaries of the paradigm. Paradigm testing occurs only after persistent failure to solve a noteworthy puzzle has given rise to crisis. This crisis must create enough discomfort to force many individual scientists to question the fundamental way they see the world. And even then, the testing can occur only after the crisis has produced an alternate candidate for paradigm. Then the two candidates can be compared.

Comparing the Two Paradigms

This testing does not involve comparing the old paradigm with nature. Instead, it involves comparisons between the two paradigms, in a competition for acceptance by the scientific community. If the new paradigm is to replace the old, the majority of that scientific community must experience a shift of world view. The new paradigm can't ignore all the knowledge of the old paradigm. It must encompass a lot of it but may do so in a different way. However, solving old puzzles in a new way will not be a strong enough reason for the mainstream to shift to a new paradigm. The new model must solve problems that the old model cannot solve. Some of those unsolved problems will be obvious to the mainstream. The lack of these solutions is what drives the crisis that finally forces a change. Some of the unsolved problems will be problems that have not even been recognized as problems by the status quo. They are only visible within the world view created by the new paradigm.

Resistance to Change

The process of comparing paradigms is difficult. Proponents of competing paradigms may not agree on what the significant problems are. The paradigm effects one's world view – the two sides may perceive the "facts" of the world quite differently. They may not accept the same tools or methods. Shifting to a new world view is a conceptual leap. There is no halfway transition point. The shift may not happen in an instant, but it must happen completely, or not at all. So how do scientists make this shift? Often, they don't. The physicist Max Planck said: "A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it."

So, given all this, what sort of theory can gain enough traction within the scientific community to produce a revolution? To paraphrase Dr. Kuhn: A new theory that provides a new explanation for phenomena that are already well explained by existing theory is unlikely to be accepted. There is no motive for making a radical change, and no clear way to distinguish between the two explanations. A new theory that provides more detailed or refined articulation of accepted phenomena is unlikely to gain traction. Normal science consists of efforts to refine and articulate these phenomena more deeply within the existing paradigm. The efforts of normal science to resolve a critical anomaly within the conceptual framework of the existing paradigm must fail persistently and repeatedly. Only then will some members of the community start to have interest in finding an alternative explanation – even one that is outside the existing paradigm.

Lab 2: We are Not Alone

We are not as alone as we think we are. We do not need to be alone with our burdens. Are you getting help from spirit? Right now, sitting here, is there an energy flowing between you and the world of spirit? Perhaps from divine source, from a guardian angel, or from a loved one who has passed beyond the veil? This sort of interaction isn't a one way street. Sometimes the flow may be towards us. At other times, it may be away from us. If you are aware of this presence, this contact with spirit, I want you to take a little time right now to observe its activity within and around you. If you aren't aware of such an activity, I would like you to ask yourself: If this sort of a connection was to happen to me today, where within me would the door for that connection be found? If I open that door myself, right now, what happens? Take some time to do this right now.



The Mission of the Osteopathic Cranial Academy

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

PART 3

"...to teach, advocate, and advance **osteopathy**..."

And what is osteopathy? Osteopathy is not a set of techniques. According to the Glossary of Osteopathic Terminology, Osteopathy is: "A concept of health care supported by expanding scientific knowledge that embraces the concept of the unity of the living organism's structure and function. This concept emphasizes the following principles:

- The human being is a dynamic unit of function;
- The body possesses self-regulatory mechanisms that are self-healing in nature;
- Structure and function are interrelated at all levels;
- Rational treatment is based on these principles.

Dynamic Unity of Structure and Function

You've heard this all through your osteopathic medical training. But you can't know how radical, how profound this concept is to someone who was trained in an MD medical school. Allopathic physicians are generally trained to think of structure as either intact or broken. When I encountered osteopathy during my years of training at the Mayo Clinic, the concept of somatic dysfunction opened a huge new world of clinical thinking and practice for me.

Self-Regulatory Mechanisms that are Self-Healing in Nature

When we talk about self-regulatory mechanisms, we are not just discussing mechanical and molecular relationships. We are talking about a system of regulation and healing potential that includes the presence of an invisible Intelligence - a presence whose effects are palpable during the healing process

Rational Treatment is Based on These Principles

We worry that the etheric parts of our practice will be seen as "irrational" by the "normal" medical community. And right now, they may be. But that doesn't mean that we should censor ourselves. These concepts are not irrational. Osteopathic thinking doesn't replace the current paradigm's rational perspectives on anatomy, physiology, and pathology. It expands it.

"...to teach, **advocate**, and advance..."

We aren't just teaching how to physically mobilize structure. That's physical therapy or craniosacral therapy or massage. We aren't just teaching structure and function as inter-related by the physical forms of anatomy and molecular biology. That's kinesiology and allopathic medicine. We are trying to teach how to interact with the intelligence of the mechanism. This means we have to address how to interact with spirit and mind, as well as with the physical body. If we aren't doing this, then we are not performing our Mission.

Teaching the vision of Still and Sutherland means that we aren't just teaching the techniques they showed us. We are also teaching the principles that guide those techniques. We cannot separate the principles from practice. Nor does our profession want us to do so. The AOA CME Accreditation Requirements consider the teaching of these principles to be a core function of Osteopathic CME activities.

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A concept of health care supported by expanding scientific knowledge that embraces **the concept of the unity of the living organism's structure (anatomy) and function (physiology)**.

- The human being is a dynamic unit of function.
- The body possesses self-regulatory mechanisms that are self-healing in nature.
- Structure and function are interrelated at all levels.
- Rational treatment is based on these principles.

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

“...to teach, **advocate**, and **advance**...”

We want to advocate our work to the public, to our colleagues, and to the wider medical community. One vision of the OCA is to establish osteopathy, including osteopathy in the cranial field, as a recognized cornerstone of complete patient care. But we need to be realistic about the situation in which we find ourselves. These traditional osteopathic principles and practices are outside of the current medical paradigm.

It's true that the majority of osteopathic physicians in our country are practicing within the mainstream medical paradigm of molecular biology, genetics, pharmacology, and surgery. But when we exercise the principles and practices envisioned by Drs Still and Sutherland, we are practicing outside of the current scientific paradigm.

We talk about an invisible Intelligence with a capital “I” that we also call the “Breath of Life,” being present throughout the body. We describe our approach as “working with the Intelligence of the mechanism.”

There is no place within the current medical paradigm for these concepts or this language. If we are guided by a recognition that human physiology is being moved and managed by something sent forth from the Mind of the Universe, we are definitely outside the sandbox. We diagnose with our perception using a detailed and subtle physical examination that encompasses both the material and the etheric aspects of body structure. We do this at a time when orthodox corporate medicine seeks to replace all physical examination with molecular and genetic tests and imaging studies. I repeat, we – you and I – the people in this room, are practicing outside of the current scientific/medical paradigm. And the work that we do requires the physician to spend a significant amount of

time with the patient. This means that osteopathic manual medicine is not a profit center in the current corporate economic model. For so many of our younger colleagues who are working in corporate medicine, the time constraints imposed on them by that clinical setting make it quite difficult to do this work on a really deep level. So, there are huge cultural and economic barriers to the acceptance of our work by the medical mainstream at the current time.

“...to teach, **advocate**, and **advance**...”

Advancing the vision of Drs. Still and Sutherland means digging on. It means increasing our awareness of and our ability to interact with all three aspects of the human being. Yes, we need to deeply understand the physical structure. And the advanced practitioners I know are dedicated students of anatomy, physiology, and embryology.

But we also need to pursue a deeper understanding and perception of the spirit and the intelligence that are completely integrated with the Life inside that structure. Advancing osteopathy means becoming more aware of the physical presence of spirit and mind within and around our patients. These are as much an aspect of our patients as their physical bodies. In terms of the physics that we know, and the physics that we do not yet know, these more etheric forces are also physically present in the world.

You say potato, I say potahto...

Remember the Persian fable of the blind men and the elephant? We may not all describe these various aspects and events in the same ways. Our teachers have called them forces, potency, liquid light, the breath of life, a fluid within a fluid, an energy field, vitality, chi, the Etheric Matrix, the embryo, “that which comes from outside,” etc., etc.

We may not all perceive these forces and events in the same way. You might hear a light go on, I might feel a glow, for someone it is a lightness, for someone else it is a heaviness. There is no way to predict which part of their sensory cortex a student will use to interpret these subtle perceptions. But however we describe our perceptions, the fact remains that there is an elephant in the room. And we need to acknowledge this fact, get as familiar with the elephant as we can, and share our experiences with each other.

Some of us may think that it is risky for us to openly discuss our subtle perceptions, and say words like “energy” in

public. They may feel that this will lead to rejection of our work by the mainstream. They may think that it would be better to get the more understandable aspects of our work accepted by the mainstream first, while we hide the light of our more etheric activities under a bushel basket.

I do not think that this is a successful strategy.

If we recognize that we are practicing outside of the current paradigm, then we can see that when our work is successful, to those inside the paradigm this looks like an anomaly. We need to understand that for our work to really be accepted as part of the standard of care, a paradigm shift – a scientific revolution – will have to occur. And there is no “halfway house” with paradigm shifts. “Comfortable,” unthreatening anomalies do not create scientific revolutions. They just get ignored.

So, if our work is an anomaly, what will be required to get the attention of orthodox medicine? What is required, for an anomaly to radically alter scientific thinking? First, let's address some things that won't work.

Abandoning the Sandbox

The new paradigm candidate can't ignore all the knowledge of the old paradigm. It must encompass a lot of it, though it may do so in a different way.

For example, the traditional Chinese medicine model doesn't really contain any of the current medical paradigm of western medicine. It is an entirely different system. Acupuncture is acknowledged now in our world, and used in certain ways, but its existence has not created a revolution in allopathic thinking.

Traditional osteopathy is in a better position on this issue. As I said before, Osteopathic thinking doesn't ignore or replace the current paradigm's rational perspectives on anatomy, physiology, and pathology. It expands it.

Old Dog, New Tricks

But solving old puzzles in a new way will not in itself be a strong enough reason for the mainstream to shift to a new paradigm. For example, osteopathic practitioners have published research documenting how effective OMM can be in treating otitis media. This research has essentially been ignored by the “normal” medical community. They already know how to treat otitis media with antibiotics. They aren't looking for a solution to that problem...they already have a solution. And it is one that is easily applied by a physician assistant!

So what sort of anomaly might actually alter the conversation?

Dissonance

An anomaly that clearly contradicts some fundamental principle of the paradigm might do so. But osteopathy doesn't really do that.

New Science

An anomaly that is made significantly more obvious by new developments within normal science could produce greater attention. So far, we haven't had a lot of significant help here. It is true that functional MRI scans can confirm the presence of a lot of the things that we perceive regarding “energy” events inside the body. But this hasn't inspired anyone to spend \$20 million to do a study proving it to the world.

As we work with more etheric aspects of spirit and the intelligence in the mechanism, many of us find that we can perceive events within the body that are beyond the reach of our hands, and that our intention alone can have effects in the treatment process, even at a distance.

We can talk about how maybe this fits in with concepts of quantum physics, paired electron spins, etc. But that doesn't mean that these mathematical theories, which have been around for 100 years or more, have made our work more obvious to anybody.

And we also like to talk about how our work fits in with a lot of new age scientific stuff that is NOT within the current paradigm (Masaaki Emoto's water studies, the secret life of plants, etc., etc.) But congruence of our work with other ignored work that is also outside the reigning paradigm does not produce recognition, discomfort, or crisis in the normal scientific community. It just makes it easier for us to be ignored.

Fixing the Unfixable

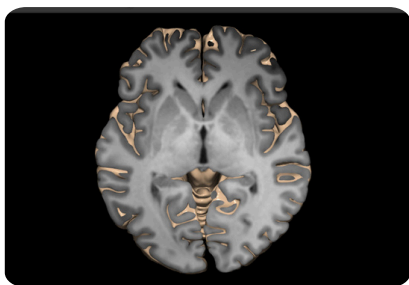
An anomaly that suggests a path to solution for a major problem, which extensive work within the paradigm has failed to resolve, is much more likely to receive attention. Because to achieve acceptance, a new paradigm candidate must solve problems that the old model cannot solve. I personally think that this is the area where our work has the most chance of producing results that might draw the mainstream's attention.

Orthodox medicine is very focused on solving problems. And our work can both explain and treat several major problems that orthodox medicine has no idea how to fix. The two problems that stand out the clearest to me in this regard are post-concussion syndrome (Traumatic Brain Injury or TBI) and long COVID.

Post-Concussion Syndrome

Post-concussion syndrome is a fairly common problem, secondary to sports injuries, MVA's, and war-related trauma. And it is a problem that orthodox medicine doesn't really have a clear handle on. They can recognize it, document it, and score it. But they don't know how to fix it.

In my experience, two primary causes of post-concussion syndrome are traumatically acquired restrictions in the motility of the CNS, and restrictions or voids in the energy fields that are normally present in the brain. My perception is that the observed changes in "energy" reflect both a reduced physiologic activity in the tissues, and a withdrawal of the presence or access of spirit to the area of trauma. The motility of the CNS is one of the five aspects of Primary Respiration that we name in our Introductory Course – but we are not currently teaching how to diagnose or treat on this level. The perception and interaction with energy and/or spirit that can help with these problems is something that we seem to be rather shy about discussing.



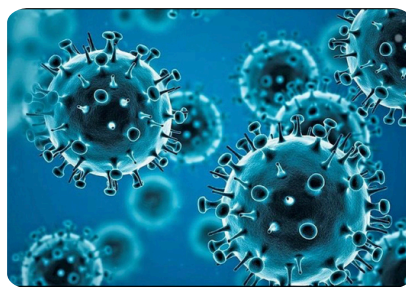
"Long COVID"

Long COVID is another problem that presents an opportunity for osteopathy to really get on the map with orthodox medicine. There are at least 50 different signs and symptoms that research has clearly shown to be associated with post-COVID syndrome, and orthodox medicine really has no idea what causes any of them. Yet most of this pathology can be quite responsive to osteopathic treatment.

In my experience, almost all of these signs and symptoms are produced by either disturbances in the energy field of various organs, or by somatic dysfunction in the lungs, mediastinum, and central nervous system. Neither of these

two forms of pathology sits within the sandbox of the orthodox medical community.

This means that their successful osteopathic treatment represents something more than simply an alternative to another form of effective treatment, that is already being applied by "normal" medical practice. And if one way to move towards a crisis that leads to paradigm shift is to produce a solution to a very important unsolved problem, nothing fits the bill better than long COVID. Because research has shown that some signs and symptoms of post-COVID syndrome are occurring in at least 30% of all people who have had the disease. And 30% of 8.5 billion people is a very important problem.



A Path to the Future

It seems paradoxical that we are most likely to produce future acceptance through the most esoteric aspects of our work – the aspects that address dysfunctions in parts of the human being that are simply not within the map of the normal medical paradigm. But these are the places where our work isn't just competing for attention as an alternative to the orthodox solution. These are places where orthodox medicine has no solution at all. Yes, these are the places where the contrast between our approach and the orthodox approach is the most extreme. But they are also the places where anomalous results will be the most difficult to ignore.

If our work has stepped outside of the current paradigm, into a bigger world, true acceptance of our work will require replacement of that paradigm by one that better encompasses the larger reality. The osteopathic vision of Dr. Still and Dr. Sutherland is a strong foundation for such a replacement. We should not abandon this vision just because radical change takes a long time.

The solution isn't to try to prove that we fit into the current paradigm. Osteopathy as we are practicing it doesn't fit in there. Attempting to look more "sciencey" and "normal" and "comfortable", and trying to blend in with normal science, will not lead to a significant change. It will lead to the continuation of the status quo, in which we are generally being ignored.

SUTHERLAND MEMORIAL LECTURE

The path towards our future acceptance is to persist in our work:

- Continuing to explore and expand on all that our elders have given us.
- Having the courage to continue working “outside the box.”
- Teaching more practitioners how to successfully use these principles in practice.
- Finding ways to document the success of our most anomalous efforts.
- And recognizing that we are in the middle of a long historical process – not at its culmination.

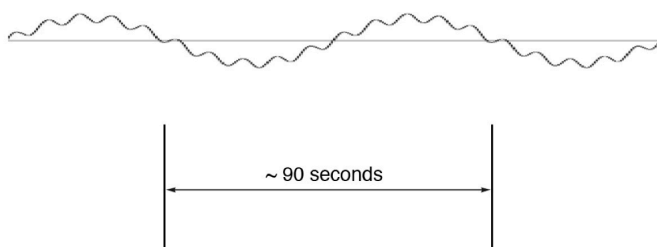
LAB 3 – The “Geo” Resonance.

OK. You can relax now. I'm done giving you advice. Now we are going to do another lab, exploring a different kind of resonance.

When we palpate our patient's bodies, we can feel various rhythmic patterns of motion. The living tissues have been immersed in these rhythms since the moment of conception. In health, all tissues of the body will resonate with the normal motions of primary respiration. Energetically, it would be far too expensive for them to do otherwise!

When pathology in the tissues creates an imbalance or distortion, it will disrupt this resonance. Instead of expressing rhythmic motion, the tissues may be doing something else. Obviously, examining for the presence or absence of resonant harmony with the PRM can be a powerful diagnostic tool.

Here is an illustration of the two resonances that are most commonly discussed in our work. We're all familiar with the “8-12” cycles per minute rhythm of the PRM, which corresponds to the CRI's motion in the cranial base and vault. A slower 90-second cycle of motion called the “long tide” is also present in the tissues.



The boats rock in the waves. They also rise and fall with the tide. Each boat moves independently in the waves. All of the boats rise and sink together, with the rising and falling tide.

In my experience, the “8 to 12 per minute” rate varies from person to person, and changes within a given person from time to time, depending on their autonomic tone. But I experience the about-90-second cycle of the long tide to be a constant rate, and it seems to move in synchrony through every living thing, waxing and waning within all of us in unison.

Inanimate objects do not express the rhythm of the long tide. But in 2012 while hiking in Yosemite I became aware of a much slower resonance that seemed to be moving through everything – animal, vegetable and mineral. It was easiest to perceive this by palpating the granite bedrock, since the other faster resonances weren't present there. Each cycle of this resonance seemed to last more than 13 minutes.

We called this the “Geo” rate because it seemed like everything in the world was moving with it in unison. We had to call it something. But you should take this name with a grain of salt. Call it a nickname. Because I have no idea if this motion is specific to our planet. I haven't been able to go anywhere else to look for it!

If the PRM is the waves, and the Long Tide is the tide, think of the Geo as the ocean floor. It is possible to find areas of restriction in the tissues of a patient, where the “Geo” rate of motion is not present. I think that you will find that if a part of the patient is not resonating with an event that moves the entire world, this can be very clinically significant. Achieving a resolution of such restrictions can produce dramatic positive effects.

In this lab, we are going to see if we can perceive this slow rate of motion in the environment. I expect that it will be easier for you to perceive this in inanimate objects, where the other rates are not present, and perhaps easiest in more rigid objects that don't alter shape when you touch them. For example: The edge of the table or chair, a glass or hard bottle, a plaster or wood wall, or the floor under your feet.

Once you find this rate in the world around you, maintain that contact with half your attention, and look into yourself with the other half, to see if you can find a corresponding motion in yourself. This may be easiest to observe in your harder tissues (your zygoma, your femur or tibia, or your feet on the floor). And of course, if the Geo is expanding, it will stand out in clearer contrast when the long tide and CRI are receding in your tissues.

Once you are comfortable finding this resonance, when you return to your office you will have plenty of time to take the next step. This would be finding a place in your patient where the “Geo” is present, maintaining contact there with one hand, and then with the other hand, and the other half of your attention, looking to see if there is any place in them where the “Geo” is NOT present.

Paul Dart, MD, FCA 2026 Sutherland Memorial Lecturer



Paul Dart MD FCA graduated from Mayo Medical School in 1984, and completed an internship in Family Practice at Oregon Health Sciences University in 1985. He started studying osteopathy “on the side” during his medical school years, and became a member of the OCA in 1988. Paul has taught on the OCA faculty for many years, as a table trainer, lecturer, and course director, and has designed several of our intermediate courses. He has served on several of our committees, acted as the Medical Associate Representative to the OCA Board of Directors from 2005 to 2008, and chaired the Continuing Education Committee from 2005 to 2015. He received his OCA Competency Certificate [now titled *Proficiency*] in 1992, was made a Fellow of the Cranial Academy in 2005, and was presented with our Exceptional Service Award in 2009. He continues to practice part time in Eugene, Oregon.

2027 Annual Conference



Communicating with the
Living Digestive System

Conference Director:
William M. Foley, DO, MSc

Assistant Conference Director:
Nicole Peña, DO

June 17-20, 2027

Westin Indianapolis, Indiana

It is my pleasure to introduce the 2027 Osteopathic Cranial Academy Annual Conference, which will be held June 17–20, 2027, at the Westin Indianapolis.

I am honored to serve as Conference Director alongside Assistant Conference Director Dr. Nicole Peña. Together, we are excited to welcome an extraordinary faculty of internationally recognized osteopathic physicians and educators for what promises to be a memorable, thought-provoking, and clinically enriching meeting.

The inspiration for this conference began at the 2024 OCA Annual Conference, directed by Dr. Kathy Gill, where I presented a lecture and laboratory on the embryology of the gastrointestinal tract. Following that presentation, our current president, Dr. Julie Mai, suggested that the topic deserved a broader exploration. That conversation ultimately led to the theme of our 2027 conference:

"Communicating with the Living Digestive System."

At first glance, the digestive system may seem an unexpected focus for an Osteopathic Cranial Academy conference. When many think of osteopathy in the cranial field, they naturally think of the cranium, cranial bones, or the central nervous system. Yet osteopathy in the cranial field is fundamentally concerned with Primary Respiration and the Breath of Life. Through that lens, the digestive system provides a remarkable opportunity to explore some of the deepest principles of osteopathic medicine. Osteopathy has always been about wholeness.

It teaches us that no tissue, organ, or physiologic system exists in isolation. It challenges us to recognize the interconnectedness of structure, function, and health. Most importantly, it invites us to listen to the inherent wisdom of the body and to cooperate with the forces of life, creation, and healing.

William Garner Sutherland expressed this beautifully when he wrote:

"Our job is to cooperate and communicate with the laws not framed by human hands."

That principle serves as a guiding theme for this conference.

We are going to review and study the anatomy, physiology, and embryology of the digestive tract from beginning to end. When we speak of communicating with the living digestive system, however, we are discussing far more than the stomach or intestines. We are exploring a living, dynamic system that exists in constant relationship with every aspect of human physiology and human experience. Participants will examine the digestive system's intimate relationship with immune function, cardiovascular physiology, fluid exchange, and the microbiome. We will explore the interconnected roles of the central, autonomic, and enteric nervous systems, including the increasingly recognized communication pathways of the gut-brain axis. We will investigate the digestive system's influence on endocrine regulation, emotional health, adaptation to stress, and overall physiologic resilience.

2027 ANNUAL CONFERENCE

We will also consider the musculoskeletal and fascial relationships that influence visceral function, including the effects of ligamentous and myofascial strains, diaphragmatic motion, and structural adaptation. Perspectives from embryology, biodynamics, energetic concepts, fascial continuity, and visceral osteopathic models will further enrich our understanding. This will not be a one-dimensional conference. Rather, it will be an opportunity to explore the digestive system through multiple osteopathic traditions while gaining practical clinical insights that can immediately enhance patient care.

Our faculty will revisit Dr. Robert Fulford's concepts of shock and its influence on health, adaptation, and visceral function. We will examine William G. Sutherland's observations regarding the abdominal viscera, including his teachings on sacral sag, fascial drag, and visceroptosis. Through a Biodynamic perspective, we will explore how the Breath of Life expresses itself through visceral tissues and how principles such as fulcra, seams, inertia, and stillness may be used to support positive physiologic change.

Additional presentations will explore visceral approaches, historical teachings preserved through Sutherland's students, and contemporary clinical applications developed through decades of osteopathic practice.



As an attendee:

You will leave this conference with a deeper appreciation for the digestive system, not simply as a collection of organs, but as a living, communicating system that reflects the health and wholeness of the entire person.

You will gain new clinical tools that can be used immediately in your practice.

Your understanding of osteopathic principles will deepen.

And perhaps most importantly, I hope you leave inspired to listen more carefully to what the body's innate Intelligence is already trying to communicate.

Because ultimately, that is what osteopathy asks of us.

To listen.

To observe.

To cooperate and communicate with the laws not framed by human hands.

We invite you to join us in Indianapolis as we explore one of the most fascinating and interconnected systems in the human body. We believe this conference will challenge assumptions, deepen perception, strengthen clinical skills, and offer practical insights that can immediately enrich patient care.

Dr. Peña and I look forward to welcoming you to Indianapolis in June 2027 for what we believe will be a truly exceptional conference.

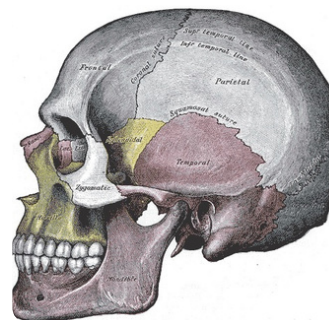


Cranial Articular Surfaces; Facial Area

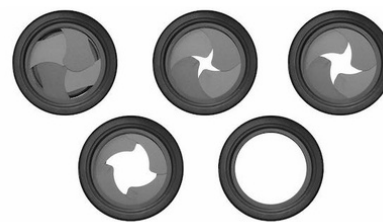
Excerpted from Commentaries on Dr. Sutherland's Recordings; Compiled by Harold I. Magoun Sr., A.B., D.O., M.Se. (Hon.); SCTF, 1961. Excerpted with the kind permission of the Sutherland Cranial Teaching Foundation <https://sctf.com/>

The third unit is the facial area with its components hung from and mainly influenced by the sphenoid. Special significance is attached to certain structures in the facial area because of their physiological capacity as accommodative mechanisms or "speed reducers" for stepping down motion in the facial area. The two palatines function between the pterygoid processes of the sphenoid and the tuberosities of the maxillae. The two zygomae function between the temporals and the maxillae. The vomer acts as a movable link between the body of the sphenoid and the intermaxillary nasal crest. All of these allow for considerable latitude in maxillary movement without excessive disturbance of the adnexa.

While accommodative function is present in all cranial articulations, pterion is somewhat unique with its beveled overlap of the frontal, parietal, sphenoid and temporal, from within outward in that order, resembling a camera shutter in arrangement. It is a very important adaptive mechanism when trauma crowds this area. And the same is true at the maxillary hiatus as partly closed by processes of the palatine, ethmoid, lacrimal and inferior turbinate.



Henry Gray (1918) Anatomy of the Human Body
<https://commons.wikimedia.org/wiki/File:Gray188.png>



<https://photo.stackexchange.com/questions/127993/how-is-uniform-exposure-achieved-when-using-a-leaf-shutter>

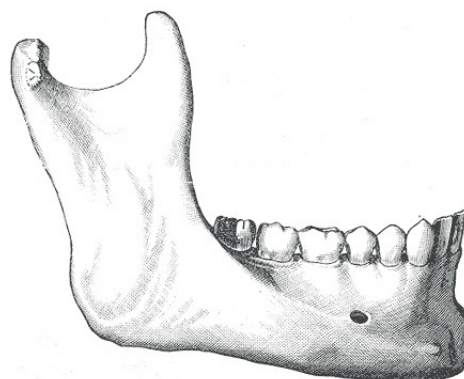
"The Mandible"

James Jealous, D.O. (Jennifer Weiss, D.O. editor), An Osteopathic Odyssey. Tame Pre-Press, 2015, p.62

Excerpted with kind permission of Anna-Maria Jealous, on behalf of Samuel James Jealous. Further details and associated material are found at <https://biodynamicsofosteopathy.com>

"...The mandible, like the frontal bone, is two bones; they move as paired bones in the adult as well as the child. These two bones should share a single fulcrum and a single motion towards lamina terminalis during the involuntary inhalation phase. Normal motion is a receding towards lamina terminalis during inhalation with a widening across the transverse axis. It gets shorter and fatter, so to speak. However, the two sides often have very different patterns.

"The mandible has three dimensional internal motion that is whole. When lesioned it can take on very distorted unilateral intra-osseous motion. If one synchronizes with the motion present during the inhalation phase therapeutics will occur and demonstrate what we propose as the normal physiological motions."



Henry Vandyke Carter
<https://upload.wikimedia.org/wikipedia/commons/4/42/Gray184.png>



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