

Debating the Osteopathic Dysfunction

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The osteopathic dysfunction (or "somatic dysfunction") is outdated, unrealistic and flawed: a thought that may well strike fear into the hearts of many an osteopath!

But while this may not be entirely true, it is not far from the truth – at least as far as my understanding goes.

Even as recently as December 2002 when the American Osteopathic Association released the 2nd edition of their osteopathic tome – "Foundations for osteopathic medicine" we were lead to believe by this governing body that the osteopathic dysfunction can be reliably identified through the TART criteria:

- **T** issue texture changes
- **A** symmetry
- **R** estriction
- **T** enderness

This is where the problem starts. It's not that there's anything wrong with the TART criteria – it's just that it's not all right either. I would suggest that under the guise of "R" we state "Range of motion dysfunction", rather than simply "Restriction".

If we were to ask our physiotherapist colleagues to critically analyse our osteopathic dysfunction – and let's face it – even if we hold prejudices about physio's we can't discredit them completely; research clearly shows their efficacy in treating patients is insignificantly different to ours. Nevertheless, it seems many an osteopath still tries to imagine themselves into a position of seniority when "osteopath" and "physiotherapist" are mentioned in the same sentence. For our modest physiotherapy colleagues quizzed over the osteopathic dysfunction, I suspect they would simply smile and point us in the direction of Panjabi's model of joint stability (1992).

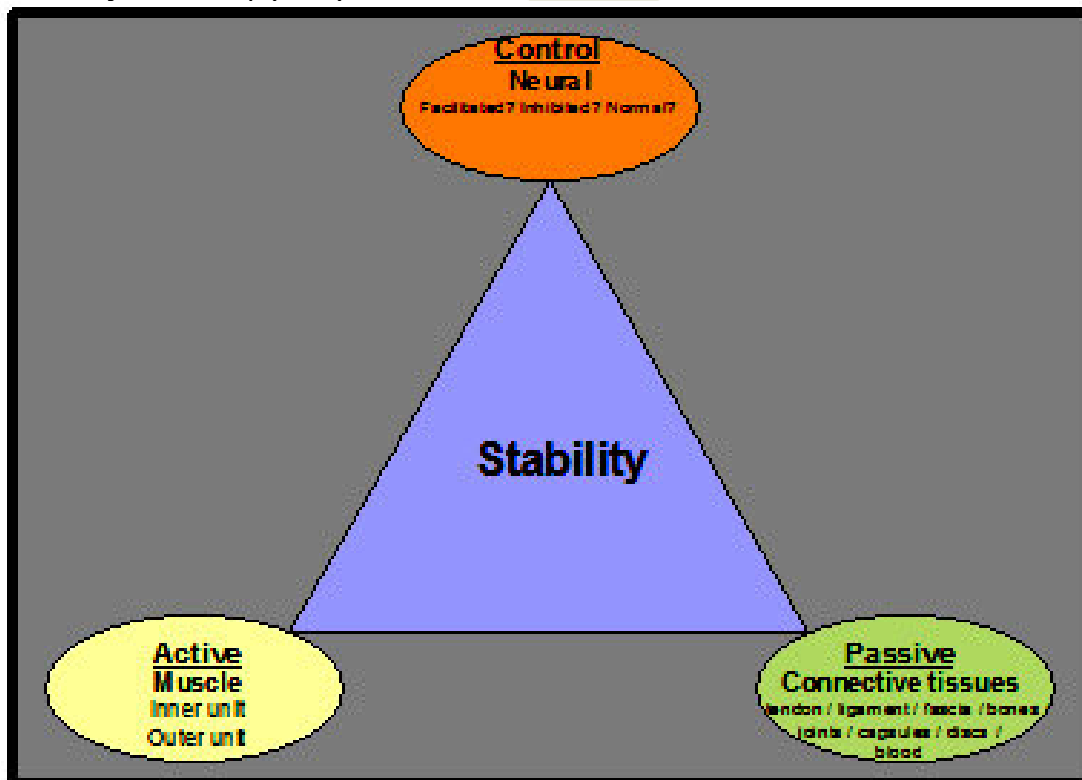


Figure 1: Panjabi's (1992) model of joint stability. All three corners of the model must be functional for a joint to demonstrate ongoing stability.

The model describes how stability within a joint is maintained by 3 main factors: active stability, passive stability and motor control. Active stability, of course, pertains to the muscular system; passive stability to the passive tissues (ligaments, fascia*, joint capsules, cartilage), and motor control to the neural subsystem which orchestrates stability.

*fascia has now been shown to contain smooth muscle cells, so could be construed as falling half-way between active and passive corners of the triad.

The problem that should become instantly apparent is that we do not leave any space in our osteopathic definition for hypermobility, instability, or compromised motor control. The reams and reams of high-quality research that has been presented over the last 15 years (in particular by our physiotherapy colleagues) should give us a hint that these latter 3 factors ("hypermobility, instability and compromised motor control) are consistently implicated in musculoskeletal dysfunction. In fact, it has been shown that just one episode of low back pain results in compromised motor control of the lumbar multifidus and consequently local instability (Hides et al 1996).

As practitioners of "holistic medicine", we osteopaths may question the simplicity of Panjabi's model, by referencing the triad of health (sometimes known as the naturopathic triad) in figure 2.

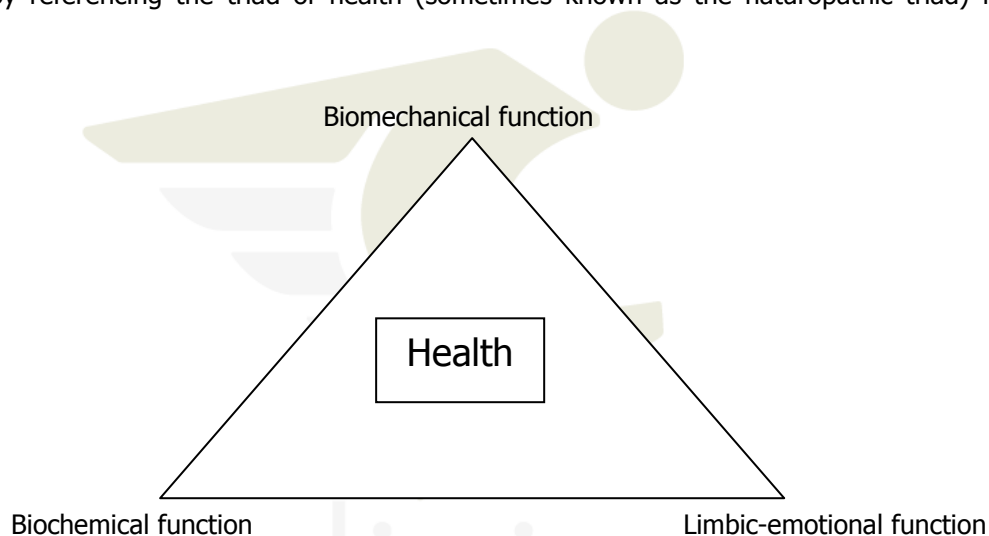


Figure 2. The naturopathic triad (or triad of health). This holistic model embraces the major factors that contribute to good health. When these factors are all functioning correctly and are in balance, the outcome is health. Failing to consider the balance of these factors in our patients' rehabilitation may result in a delay or failure to recover.

The naturopathic model surely demonstrates that Panjabi's model is extremely limited in its approach – not taking into account nutritional, emotional and other energetic issues that are represented by the triad of health.

However, before we get excited about the fact we may have "one over" on our physiotherapist colleagues, I should point that, firstly, Panjabi's model never proclaimed to be a complete model of patient health – it was purely designed to be a joint stability model. Secondly, Diane Lee - one of the world's great physiotherapists who many of you will be aware of through her text books, papers, videos and world congresses, has already started to build a new expanded model of joint stability to include emotional and nutritional factors (Lee 2003). Her pentagonal model is more akin to what we have practiced as holistic practitioners for some time.

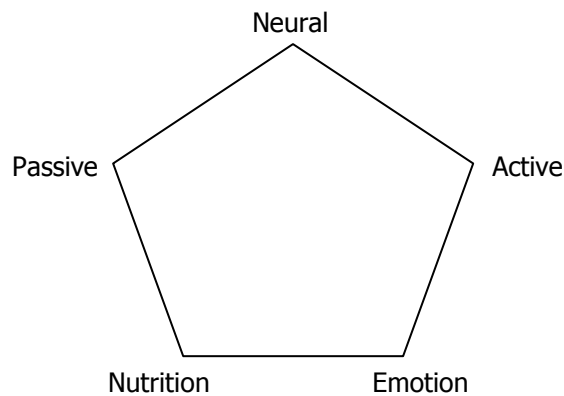


Figure 3: Lee's proposed model (2003) of joint control.

Chek has also incorporated this and far more encompassing models into the healthcare system he and his CHEK Practitioners have provided for more than 10 years now (See Chek 2004).

Change in Osteopathy

The point I am coming to is that we often feel that we have something different, something unique as osteopaths, and this may be true. The problem is that we seem to be content to sit back on our principles, dismissing new research and models as unnecessary to our great profession of osteopathy. Personally, I feel this is short sighted.

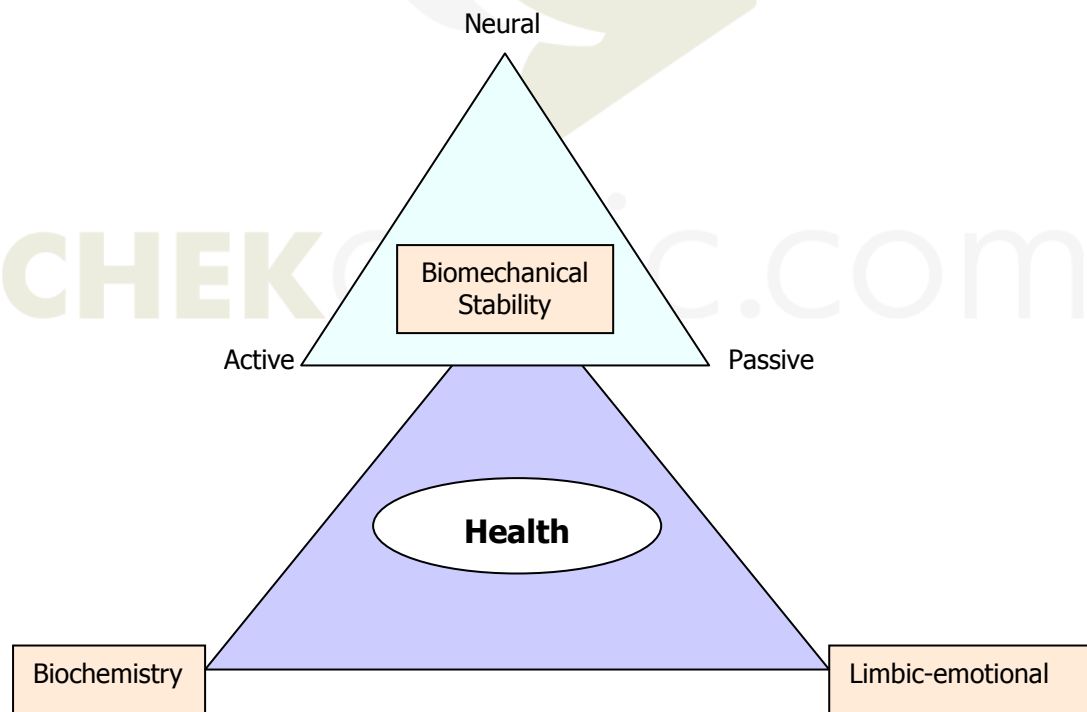


Figure 4: Proposed model of joint control. As osteopaths we're aware of how limbic emotional factors are often somatised into the tissues to create biomechanical dysfunction. We're also good at recognising viscerosomatic reflexes – where an inflamed organ, for example, has influenced the neural component of joint stability to create an inhibition, or up-regulation of overlying muscle tone (active system).

So, if the osteopathic dysfunction is defined by restriction (Ward 2002), are we not missing a large proportion of potential diagnoses? I wonder, would our physiotherapist and CHEK colleagues suggest that many a somatic dysfunction may be a secondary homeostatic response to an earlier instability?

I know that as an osteopathic student I was indoctrinated into the thinking that it was restriction that created hypermobility – a kind of somatic dysfunction one-way street. Yet the research and clinical evidence also shows that visceral dysfunction can inhibit neural impulses to the muscles – as does pain.

If we were to exclude all patients that came into our clinic who are in pain or have visceral dysfunction, we would exclude probably our entire patient base - *and* most of the rest of the UK population too!

This means that most patients we see will potentially have loss of motor control in some parts of their biomechanical chain – which must be compensated for by up-regulation of tone in other parts of the chain. Once upon a time, I used to think that simply manipulating or mobilising the tight joints would take the stress off the “loose” joints. How wrong we can be?

What I have gained in physiological understanding, I have lost in fraternal understanding... I simply cannot comprehend why there are so few osteopaths out there embracing this work. Is this just a case of oste-apathy? Or us osteopaths trying to hold on to our autonomy?

I'm all for sticking to foundation principles if they work... and if there's not a better model. I'd like to think that if I had trained as a physiotherapist I'd still be as good at helping my patients as I am as an osteopath – so I don't really buy the “us versus them” debate. In fact, it only takes one read through the Journal of Bodywork and Movement Therapies to realise that there are massage therapists and many others out there who many might consider our “subordinates” that we can learn inordinate amounts from. Let's face it, the figures show that we're no more effective than other manual therapists – or if we are, it's by 0.21 of a treatment... You ever given one of those?

I have heard it said that osteopaths who use exercise, nutrition or other modalities to treat patients do so only because they are not good osteopaths! To me this statement is in such contradiction to how I view our role as osteopaths, it is laughable. My vision of osteopathy is that it is an holistic, gentle modality that works with the individual to support their homeostatic balance. Those that believe other modalities do not belong in osteopathy can only believe this because their primary objective is to “keep osteopathy distinct” rather than to help the greater masses – for the greater good. Their focus can surely only be on keeping osteopathy isolated and separate and unique... my focus is to help my patients in any way I can. What's the focus of your practice? The concern is that if we focus on distinction, the result may be extinction.

The old yang-based, paternalistic treatment-based paradigm of “I will do this to you”, or “I will give this for that”, is making way for a new yin-based, maternalistic paradigm (Capra 1975) – where patients are empowered through education and effective self-corrective measures. This hands control and responsibility to the patient; which as we know is the only true long-lasting way to help individuals. Liebenson (1998) has described that this patient control is one of the key factors in successfully managing chronic pain patients. It is the classic analogy: “*give a man a fish and he'll eat for a day, teach him how to fish and he'll eat forever*”. Are you handing them out, or teaching them how to do it themselves?

Clearly this article is written to stoke a few flames and to create a hearty response. Nevertheless, it is a debate I feel we have shied away from for too long, and we will soon be left behind if we do not embrace the research coming from all quarters that can benefit our patients. Let's hope that sticking to the “osteopathic dysfunction” as we know it, is not the biggest Osteopathic dysfunction the profession could conceive.

Let the debate begin!

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