HVLA and the Sutherland Model

Learning Objective:

It is notable that this is the first AAO conference dedicated to the work and some of the interpretations of Dr. William Garner Sutherland’s Cranial Concept. As noteworthy as that is, osteopathy should look forward to the inclusion of its principles applied to the entire body including the cranium in all presentations.

The Course Director asked me to give this workshop because of my training and initial practice of HVLA and the experience of converting my practice to primarily utilizing the methods of Dr. Sutherland: LAS, MAM and PRM. What has never changed is that I trust Osteopathy and that I use in my work the principles that I have been taught from my training at PCOM to the present.

My assignment includes addressing a rift or abyss between HVLA and OCF. An abyss could be viewed as something left out and in this case that space is something to be learned or remembered. H.V. Hoover, DO quotes A. T. Still, DO, MD in the 1949 AAO Yearbook, with regard to instruction, “The only assistance others can give you will be a better understanding of fundamental principles.” I’ll address some fundamental principles in four brief divisions including the practical:

Penetrating the Forest
The Breadth of Osteopathy
The Breath of Osteopathy
The Frontier

2. Syllabus:

Penetrating the Forest
“...Your own native ability, with nature’s book, are all that command respect in this field of labor. Here you lay aside the long words, and use your mind in deep and silent earnestness; drink deep from the eternal fountain of reason, penetrate the forest of that law whose beauties are life and death. To know all of a bone in its entirety would close both ends of an eternity.” (Autobiography of AT Still p 152)

Case Story 1: observation of involuntary motion
Anne F. was a patient with persistent post MVA low back pain who had seen many different providers. I was treating her using HVLA at the time of my first SCTF Basic course in OCF...

Osteopathy is a philosophy of health care, and a distinctive art supported by expanding scientific knowledge

AOA Glossary

Osteopathy is first a way of thinking. We make its teaching our own in practice. Osteopathy as a diagnostic science, gives us the opportunity to evaluate our patients and our treatment-no matter the approach, on the effect it has on the fundamental physiologic motion described as the Primary Respiratory Mechanism.
The Breadth of Osteopathy
Case Story 2: HVLA-the still and the motion

Our family visited Dr. Wesley Dunnington (Narberth, PA) at his home in retirement. There is no doubt that my memory of an event at 6 years old looking through a car window could be somewhat faulty, no matter, it’s my story and I’m sticking to it.

As we were leaving, like all good patients, my father was pointing out, as an afterthought, that my brother had sprained his finger…

In a time that was already losing the teaching of Dr. Still, William Garner Sutherland, DO had taken to heart and open mind that same teaching about the Intelligence within the body, the perfect machine, designed by the God of Nature, self-healing and self-regulating.

In addition to developing the principles taught him hand on hand from Dr. Still for treating the axial skeleton and appendages as a ligamentous articular mechanism, Dr. Sutherland reasoned to the integration of a membranous articular mechanism that included not only the visceral fascia, but a mechanism for motion of the cranial bones.

After noticing the bones of the skull had sutures consistently formed in a shape that allowed for motion and after demonstrating that motion, he had to account for motion without muscular agencies. This was huge and we just don’t appreciate it today!

- From his exposure to Still and his personal study he had surmised that the machine had a spark ignited by the Breath of Life,
- that the sutures of the cranium had a distinct design for motion.
- He discovered that when he willingly stopped the observed motion of his brain that a motion-a fluctuation-of the CSF remained in the area of the anterior brainstem.
- He reasoned a way to compress and change the shape of the fourth ventricle to affect the potency of the fluid within it and the primary centers in its floor. In doing so, he observed an alteration in his sacrum and
- reasoned from a reciprocal tension in the dura of the cranium to a core link of spinal dura that functioned reciprocally between the sacrum and the cranium.
- The sacrum has no muscular agencies to account for its motion.

All of these findings he reasoned as features of a whole. He called this the Primary Respiratory Mechanism composed of four features:

| The Fluctuation of the CSF |
| …the first feature…‘a thought strikes him that the cerebrospinal fluid is one of the highest known elements that are contained in the body and unless the brain furnishes this fluid in abundance, a disabled condition of the body will remain’ (TSO p13) |
| The Reciprocal Tension Membrane |
| These schematic names (poles of attachment) are simply to show that all the bones of the neurocranium are attached to the mechanism that moves them (TSO p18) |
| The Motility of the Neural Tube |
| The mobility of the bones…is accommodative to that motility within the brain and spinal cord and to the fluctuation of the CSF. (TSO p 19) |
| The Articular Mobility of the Cranial Bones and the Involuntary Mobility of the Sacrum |
| See how the dural membrane connects up all the parts, including the sacrum as an interosseous membrane. (TSO p 22) |
The Breath of Osteopathy
Case Story 3: the still I didn’t learn in medical school
Three weeks after a fall on his face, my 82 year old dad struggled to walk into the office using a walker. His pallor was pale gray…

I might predict that there will be many diverse opinions relative to that basic consideration in the years ahead...
There is a reason for the continuation of theorizing about the processes concerned with the subject.
It is because that hidden Breath of Life is left out.
It was recognition of the supreme potency of the Breath of Life as the initiative spark to involuntary activity that interpreted my hypothesis relative to the primary respiratory mechanism.

COT Correspondence November 30, 1943

In my opinion the best contemporary summary of OCF is 45 years old and written by Dr. Rollin E. Becker, titled Be Still and Know (1965). In it describes how to maintain and use the Breath of Life taught by Still to Sutherland, the “highest known element,” in all our work.

Tools for Understanding and Using the Spiritual Fulcrum
1 Develop an objective awareness
2 Develop a subjective awareness of potential for using the healing principle
3 Develop thinking/seeing/feeling/knowing fingers that can follow moment to moment changes.
4 Accept one thought each time a patient comes in (summary of above) "An objective, subjective, knowing awareness of a Potency within himself, within his developing knowing fingers and within the patient, a Potency to which the physician quietly submits himself for guidance and understanding."

Rollin E. Becker, DO Life in Motion p 24

The Frontier
The point that appears every now and then is that even the Osteopathic Profession does not see the magnitude of the Science of Osteopathy. That is, really, we are on a frontier. And we assume that the members of an Introductory class come with the essential equipment of physicians who practice Osteopathy. But we do not know just what that equipment means to any one person.
If anyone thinks that this subject is all wrapped up and ready to teach they are not “in the know”. This is one fact that makes life on this frontier so exciting. There is always something to be learned.

Anne L Wales, DO personal correspondence 5/19/1992

I sat on the stool at the head of the table and waited to be inspired with an indication of how to proceed, putting myself into a receptive mood.

Alice Paulsen, DO Automatic Shifting JOCA 1953
The Ligamentous Articular Mechanism is a *natural agency* for self-healing. It refers to the physiology inherent in the living continuity of joint ligaments extended to fascia, tendon, and periosteum that are necessary for the body to transmit motion and mobility; all the while—in health—balancing the forces of gravity and atmospheric pressure.

This workshop observes this mechanism as a response to Dr Still’s “highest known element” with special emphasis on the following manual procedures:
- Standing SI
- Seated Rib
- Directing the Tide-V-spread

**Standing SI (TSO p 255)**

Correction of the postural lesions is made with the patient standing hands on the table which is raised in front of him. The leg on the side of the lesion is crossed in front of the other one and the foot rests on its outer edge, lateral to the one on which he stands. In this position, the weight is transmitted from the spine through the sacrum to the innominate bone which is not directly concerned in the technique. The sacrum is thus stabilized and the lesioned innominate is left suspended. The operator, sitting at the side of the patient holds the ischial tuberosity with one hand and the rest of the ilium at the ASIS with the other. The innominate bone is rotated with the hands (within direct action balanced tension—just to ligamentous articular balance) The patient is told to begin to flex the weight bearing knee while the other leg is kept relaxed to a point where the operator feels a slight increase in motion of the innominate. Balanced tension of the whole is found and maintained as the patient is asked to: slowly return to the erect position; uncross his/her legs; put weight on both feet; and stand up straight.
Seatd rib (TSO 245-251)

For fourth to tenth ribs: The middle finger of one hand of the operator is on the angle and the middle finger of the other hand is on the anterior end of the shaft of the rib and the thumbs are placed laterally on the shaft. Firm contact is obtained by instructing the patient to leaning toward the operator. The rib is held to prevent it from moving anteriorly as the patient is instructed to slowly rotate their upper body (bring opposite shoulder back) to the point of balanced tension of the ligaments. Augmentation is added by having the patient inhale to refine the point of balanced tension and hold to change. Patient is instructed to return to “straight” and sit up while operator supports the rib.

Directing the Tide (TSO p 167; Osteopathy in the Cranial Field 3rd p 154)

“The Tide is directed gently by the touch of a finger. You direct the Tide from one point on the skull to another point on the other side. Place the palpating fingers over the suture contacting the two components with a V-spread. Balance tension across this area. Direct the Tide from the other hand using in greatest contralateral diameter of the head. The change in the quality of response shows that change is occurring in the area of strain.”
3. Bibliography


