My Osteopathic Clinical Approach was profoundly impacted by both

• Fred L. Mitchell, Sr., DO, FAAO

• George Andrew Laughlin, DO
  ( a grandson of A.T. Still, MD, DO )

• Perrin T. Wilson, DO

( Greenman’s correlation statement / unique perspective )
GOALS:

• Develop an appreciation of the profound contribution Fred L. Mitchell, Sr, DO, FAAO had on the A.A.O.
• Develop an appreciation of the profound impact George Andrew Laughlin, DO, a grandson of A.T. Still had on my clinical skills and OPP perspective.
• Understand the importance of identifying the A.G.R-H for understanding both Mitchell’s and Laughlin’s clinical approaches.

OBJECTIVES:

• Be able to “fine-tune” the Mitchell MET techniques
  • Appreciate the FLM, Sr, DO, FAAO mind-set concerning the teaching of M.E.T.
• Be able to do my AGR-H screen
• Be able to problem-solve the screen findings
Tell me about
Fred L. Mitchell, Sr, DO, FAAO

- Mechanical Engineer
- Creative Thinker
- Non-linear Thinker
- Tensegrity “thinker”
- utilized Cybernetics
- Complex Adaptive Systems Thinker
- Phenomenologist

- These attributes enabled Fred to develop:
  - the unique Mitchell Pelvic Axis Model
  - plus a totally new OMT approach utilizing a patient generated corrective force.
  - stressed the importance of starting your treatment at the Key S/D of the total system.

4 Tutorial participants: Greenman, Stiles, Sutton, & Ward are Legends being honored during this Convocation.
The post isometric relaxation technique begins by placing the muscle in a stretched position. Then an isometric contraction is exerted against minimal resistance. Relaxation and gentle stretching follows as the muscle releases.

Note:
- a specific S/D-H diagnosis was not established; only tight muscle(s) identified (S/D-H significance illustrated by F.L.M., Sr.’s new comprehensive M.E. diagnostic system he stressed during 1st Tutorial 1970)
  - The S/D-H description was Mitchell’s focus, not tight muscles!
    (exception: hip restrictors or rotator cuff)
  - Position against the “feather edge of restrictive barrier”
    (not stretching restricting muscle)
    - Mitchell described using an unyielding counterforce...not minimal resistance
  - Purpose: to functionally reverse the origin and insertion of the activating muscle
    - Mitchell taught us to use an isometric contraction
  - After the patient relaxed the area being treated, Mitchell, Sr. stated his goal was to “take up the slack”

- Mitchell Sr.: M.E.T. are training the muscles needed to maintain improved function.
  Mitchell Sr.: “here are the biomechanics, here’s how you diagnose it, here is the muscle you will use to correct it.”
  (my 1969 AOA Convention experience with Fred Sr.)
Tell me about
George Andrew Laughlin, DO
• Devoted to his grandfather’s Osteopathic concepts.
  • Skilled clinician
  • Role modeled amazing Osteopathic outcomes x 20 yrs.
OMT: Functional Techniques
  • Introduced me to a sutural cranial approach.
  • Enabled the development of my palpatory and “fine-tuning” skills.

P. T. Wilson, DO
• Specialed A.T. Still night he died
  • Elected student Pall Bearer
• Gave Sutherland 1st AOA lecture slot
• Wilson-Northup: AAO Founders
Mitchell put me through several paradigm shifts during the first Muscle Energy Tutorial!

- **Force**
  required for Osteopathic Techniques:
  Stool illustration

- Stiles to Mitchell, “do you use the **lymphatic pump**?”
  His response produced a total paradigm shift in me.

- **Host orientated care**, not Disease orientated care was the focus of all his clinical discussions.
  “I don’t know how to treat pneumonia with OMT, but I can show you how I would treat a patients with pneumonia in order to enable the patient’s homeostatic mechanisms to realize their health potential.”

- enabling **health to emerge** . . . Finding **Health** ? A.T. Still charge !

- “treating pneumonia with OMT is **Allopathic Osteopathy.””
Emergence of AGR-H screening examination:

• Fred’s screen focus had 4 important components
  • **Axial spine**: Cervical, Thoracic / Rib Cage, and Lumbar region
  • If thoracic, how decided to treat ribs or spine first?
  • **Pelvis sequence**: based on his sacral axis model
    • Up/ down shears of innominate
    • Pubic shears
    • Sacral dysfunctions
    • Innominate rotation dysfunctions
  • **Standing & sitting exam**: differential diagnostic tool
  • **Homunculous** significance: hands / wrists & ankle / foot: maintaining factor with many axial S/D patterns.

• Stiles’ expanded screen, based on Laughlin screen
  • **Upper extremity**: unilateral / ipsilateral vertical band of thoracic tightness
  • **Lower extremity**: unilateral / ipsilateral vertical band of lumbar tightness
  • **Upper cervical / dural**: do cranial pattern / sutural screen
  • **Mitchell & Kimberly**:
    Match OMT technique to the nature of the Restrictive Barrier!
Paradigm Shift: 2018
looking at familiar data, come to new understanding &
new way of explaining old observations

“Learn the principles and get them
to work for you.”
Paul E. Kimberly, DO, FAAO
Tensegrity structures are:

• Light weight
• Much stronger than experts had predicted
  • Multi / Omni - directional
• Whole system adapts to stressors
• Protects the “weakest link” / the A.G.R.
  • defy gravity
• Non-metallic materials, organized in a Tensegrity arrangement, can conduct electricity
• ‘wired’: keep eyes level, evenly distribute weight among all 4 quadrants.
• Conduct vibratory information
• Would it not make sense to identify, the A.G.R.
  ( area of greatest restriction - hindrance )
  in this flexible & adaptive system?
MESOKINETIC SYSTEM

Meso (mesoderm): gives rise to

• Connective tissues & fascia
  • Cartilage
  • Bone
• Striated and smooth muscle
• Myocardium and pericardium
• Blood and lymph vessels
  • Kidneys and ureters
  • Adrenal cortex
  • Gonads
• Tubes, uterus and upper vagina
• Serous membranes lining the body cavities (T, A & P)
  • GI fascial support system
  • Spleen

**Kinetic:**
Related to movement of physical objects

**NOTE:**
S/D might impact both skeletal & visceral structures.
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Netter’s Atlas of Human Embryology
LBP patient
A.G.R.

( Stiles: 100 patients )

• T/RC = 60%
• Lumbar = 24%
• L.E. = 11%
Total: 95%

Note:
Sacrum and innominate were not the #1 A.G.R.!

Other possible A.G.R.s
• Cranial: dural tube
• U.E.
• L.E.

• Note: ever see a LBP research strategy which considered S/D in UE, LE or cranial?

may have been treated later in the treatment sequence
In light of this complexity reality, how do you clinically view your patients?

**Stiles’ Current Perspective**

complex, dynamic, inter-connected & inter-woven, multiple, simultaneously functioning systems, non-linear, autopoietic functional unit
• “Dr. Still was keen on being very specific.
• He looked at the patient as a Totality.
• He looked for the Elusive Key Lesion – Hindrance that people have quoted for years”.

• That is what He looked for and when He found it, He fixed it and then left it alone.
  He said that once done, the body will do its own work because it is designed to do its own work.
• Our job is to find the Key Restriction – Hindrance to homeostatic integrity, and once restored to normalcy, to rest assured that the body will take care of the rest of the work”.

Passing on the Tradition
Alan Becker, DO, FAAO  2010
Journal of AAO – fall edition
Without data you're just another person with an opinion.

W. Edwards Deming

Note:
I am not saying AGR / sequencing is the only way to approach patients!
but
our data suggests it is an effective clinical strategy

Stiles’ Data: methods
- **Spinoscope** / Gracovetsky
  - sEMG evaluation
- **Ground Reactive Force**
- **Fractal Analysis**
- Reactive Fractal Analysis
  - **golfers**
- **Elite female runners**
- **Dynamic Athletic Research Institute (DARI)** Jason Hunt, DO - orthopod

Sequenced OMT
Sequencial treatment of a patient is like “following” a bouncing football

Fred L. Mitchell, Sr. DO, FAAO

Realized how significant when I treated Fred’s patients!
M.E.T. TECHNIQUES:

Focusing on:

• how Mitchell, Sr. taught MET techniques

• Appreciate Mitchell, Sr’s “mind-set” about MET

If start utilizing these principles

• Your MET results will improve!
TECHNIQUE OPTIONS:

Goal: to demonstrate FLM, Sr’s teaching style

- “Minimal S/D & maximum adverse physiological effect”: Kimberly & Mitchell
- “widespread Type I adaptations secondary to Type II S/D”
- “what are the tight muscles protecting, find that and fix it”

- \textbf{T}_{12} \text{FRS}_{L}: 2 step technique: “getting principles to work for you” - Mitchell
  - Step 1: use Type I mechanics to reverse the rotation of a Type II S/D
  - Step 2: use Type II mechanics to end up against the “feather edge” of restrictive barrier

- \textbf{T}_{3-11} \text{FRS} with kyphosis: 2 step technique ( “getting the principles to work for you” )
  - Step 1: Use Type II mechanics in flexion to reverse the side bending and rotation
  - Step 2: use extension to end up against the “feather edge” of restrictive barrier

- \textbf{L. sacral flexion}: [ include original L/L sacral torsion ] Honor patient uniqueness!
  - “fine-tuning” to make it easier for the body to respond effectively
  - Add / abd “fine-tuning” & localize to MTA: sacral uniqueness [ book: 15° ]
  - IR / ER “fine-tuning”: good linear thinking [ book: I/R to “gap S/I joint” ]
  - Identifying the appropriate vector on L. ILA for that “L” shaped joint / enable to glide

- \textbf{Innominate rotational dysfunctions}: utilizing the appropriate sacral axes ( ITA )

- \textbf{Rib cage dysfunctions}
  - Key rib concept: FLM, Sr. first to teach this principle
  - Pump-handle technique principles: expired / Fred’s thought process!
  - Bucket-handle technique principles: mechanical advantage point

- \textbf{O/A diagnosis}: 3 options . . . Have reason for one you choose
  - Active testing: the one preferred by Fred Sr.
  - With head rotated 45° / introduce A/P gliding along the condyle
  - Didn’t use the side gliding diagnostic test: gliding oblique to condyle

- \textbf{C 2-7 segmental diagnosis}: with focus on facet function
  - Facet pair locked open ?
  - Facet pair locked close ? Question: can you get a FRS & ERS S/D at the same level ?
MET Techniques: additional thoughts

• **Laughlin’s influence**
  enabled Stiles to pick up on FLM Sr’s “fine-tuning” . . . . saw that with Laughlin but was using a direct approach.

. **Kimberly:**
  learn principles and get them to work for you. Then you don’t have to work hard or force dysfunctions.

• **Using axes during treatment:**
  • Hip restrictors using appropriate sacral axis
  • R. A/I rotational dysfunction: use ITA
Stiles’ Screening Examination

Combines
Fred L. Mitchell, Sr.’s axial skeleton screen

With
George A. Laughlin’s extremity screen

With
Stiles’ upper cervical dural screen
Screening Examination

- Standing: both sides
- Sitting: both sides
  ( screen from occiput to S/IJ )

**Key:**

- using LAW III of spinal mechanics
- utilizing Tensegrity & Ground Reactive force principles

- Use
  slow deliberate movements
  ( miss restrictions when screen too fast )

  - Blend
    into the “feather edge” of the restrictive barrier
    ( getting into joint mechanics vs just soft tissues )

  - Palpate / “listen”
    to the tissue response
    ( developing a “cybernetic loop” )
  - looking for the most restricted area
    ( may be a very localized area )
  - looking for area that has the “hardest end-feel”
    ( has lost its variability & least healthy feel )
Additional Examples of A.G.R. / sequencing Outcomes

**GOAL:** stimulate your interest in Finding AGR & sequencing
A.G.R. Findings:
- L⁵ “out of pattern” with the sacrum
- Sacrum: torsion “counterfeit”
- Treated L⁵ FRSL
- Released well and sacrum normalized
- Retested on treadmill

- Post LB surgery (stenosis) 1 year
- Recent flare-up of LBP & sciatica
  - Symptoms improved markedly

*Case Study 1
Pre-Treatment
#2 A.G.R. FINDINGS:
• Right S/S suture
• Right GWS / F suture
  “L” shaped surface
Dural tube role in LBP?
• Right P/S suture
  retested

*Case Study 1
Post-Treatment 1
LBP & sciatica cleared

Balanced out after sequenced cranial (sutural)

*Case study 1
Post-Treatment 2
**NOTE:**

after sequenced O.M.T.

#1 - treated L₅ of “counterfeit torsion”

#2 - treated 3 cranial sutural dysfunctions

Immediate Muscle activation pattern Changes.

“find it ( S/D-H ), fix it & leave alone”

A.T. Still, MD, DO

- Almost 100% change: immediately!
- Median of 60 gait cycles (tons of data)
- Honors complexity & uniqueness of each patient
- Can compare points for statistical and fractal significance
- Each patient their own research project (N of 1)
Lessons learned from this patient?

• Treating the 1st S/D, L₅ out of pattern with “torsion”, made some changes ( +/- ).
• From the history, sounded like Postural Model patient
• 1st S/D treatment uncovered the cranial AGR S/D.
  • Once sutural cranial approach was utilized to treated the cranial AGRs, the patient immediately realized his health potential.
  • Ground Reactive Force documentation confirmed the clinical benefits of sequenced OMT.
• The G..R.F. findings were both statistically and fractally significant.
Vleeming – Fryer
“Controversy”

The Mitchell Pelvic Model is an consistent model considering the findings and tests

Stiles’ Perspective:
They did not appreciate how important finding the A.G.R. and sequencing was to Mitchell, Sr.

When sequencing, Mitchell type, is not utilized, Vleeming is correct

When sequencing, Mitchell type, is utilized, the Mitchell Pelvic Model is consistent as originally described for findings & tests.
( prove to yourself during workshop )
HOW APPLY PRINCIPLE III?

- MOTION HAND
- LISTERNING HAND
- CHALLENGING HAND (FOR HARDEST “END-FEEL”)

USE “BLENDING PALPATION”
- IS IT MYOFASCIAL?
- IS IT JOINT MECHANICS?

AM I GETTING A NORMAL OR ABNORMAL RESPONSE TO MY INTRODUCED MOVEMENTS?
SEQUENCING: examination

- ALLOW THUMB TO REST LATERAL TO SPINOUS PROCESSES BUT MEDIAL TO T.P. = OVER FACETS OF ALL THE CERVICAL VERTEBRA

- WHILE IN NEUTRAL, SLOWLY INTRODUCE SIDE BENDING & IPSILATERAL ROTATION (activating Fryette's Law III)

- BLEND INTO THE TISSUES TO MONITOR CYBERNETIC RESPONSE

- THEN SLOWLY INTRODUCE FLEXION / EXTENSION: WITH EACH INTRODUCED MOVEMENT UNTIL IT SEGMENTAL MOVES DOWN TO THE BASE OF THE THUMB

- WITH MOTION INTRODUCING HAND, VECTOR TOWARD “LISTENING HAND”, THIS ATIVATES THE GROUND REACTIVE FORCE WITHIN TENSEGRITY SYSTEM

- USE THUMB OF LISTENING HAND TO TEST EACH SEGMENTAL SEGMENT IN THE DYSFUNCTIONAL REGION

SEGMENTAL OPTIONS:

- NORMAL...
  - “PHYSIOLOGICAL LOCK”: HAS “JOINT PLAY”
  - DYSFUNCTIONAL AREA “SURFACES / UNCOVERED”: “HARD END-FEEL”
SEGMENTAL MOTION TESTING: “JOINT PLAY”

Once find the regional “lock”, segmentally spring diagonally to check the “end-feel” (3-D)

- **Normal**: Soft end-feel & springs
- **Dysfunctional**: Hard end-feel & lack of spring
OPERATOR’S “MOTION HAND”
( HAVE FINGER TIPS OVER CLAVICAL & UPPER RIB CAGE AND THUMB OVER SCAPULA & UPPER RIBS THENAR AREA OVER A/C JOINT )
VECTOR TOWARD IPSILATERAL ISCHEAL TUBEROSITY

OPERATOR’S PALPATING, “LISTENING” & “CHALLENGING HAND”

PRINCIPLE III
THORACIC, LUMBAR & SI / J REGIONS
EXAMINE BOTH SIDES
**SEQUENCING**: examination - SUMMARY

**DURING THE PALPATORY EXAMINATION**, use testing movements as follows: initially identify global D.B.P.

- **ONE HAND** introduces movement: vectored compression
- **OTHER HAND** monitors the segmental response
  - ("LISTENING HAND"... 'BLENDING PALPATION')
    - facet joint mechanics
    - parasegmental tissue response
- **IN NEUTRAL**, introduce S/B & R first
- **SLOW "Sweeping"** movements utilized
  - (tensegrity structure: 60 degree angles)
- **DELIBERATE SLOW MOTION**: interpreting the "end-feel"
- **FIRM BUT GENTLE**: "BLENDING PALPATION": explain
- With motion hand, vector toward listening hand, activates G.R.F.
- **USE THUMB** (listening hand) to segmentally spring the dysfunctional area to find A.G.R. within area: find key within the dysfunctional region

Examine both standing & sitting
Evaluate both sides
USE SWEEPING MOTIONS

(TENSEGRITY MODEL)

• SLOW
• DELIBERATE
INITIALLY
SLOWLY INTRODUCE

• SB & R: vector toward “listening hand”
  (activates G.R.F. & “floats” sacrum)
• monitor with “listening hand”
• Add F/E
• Identify the segmental S/D

DO BILATERALLY IN BOTH STANDING & SITTING

60° vs 90°
ANGLE
TENSEGRITY

REPEAT
• over LUMBAR AREA
• over S/IJ’ s
DO SCREEN

UPPER HALF?

• CERVICAL?
  • DURAL?
  • UPPER CERVICAL?
  • LOWER CERVICAL?
• THORACIC?
  • THORACIC?
  • RIB CAGE?
  • UPPER EXTREMITY?

T12

LOWER HALF?

• LUMBAR OR PELVIS?
  • LUMBAR?
  • PELVIS . . . AXES MODEL
    • UP / DOWN-SHEAR
    • PUBES
    • SACRAL DYSFUNCTIONS
    • INNOMINATE ROTATIONS
  • LOWER EXTREMITY?
First question: after screen is it upper half or lower half problem?

Upper half of the body
(\(T_{12}\) is reference point)

- **Cervical**?
  - Atypical: O/A, AA?
  - Muscular?
  - Dural?
  - Typical: \(C_2-7\)?

- **Thoracic**?
  - Thoracic spine?
  - Restriction more central
    (which thoracic vertebra?)
    - Rib cage?
  - Restriction more lateral along the related rib
    (screen rib cage)
  - Group pattern / key rib?
  - Isolated rib dysfunction?

- **Upper extremity**?

Lower half of the body

- Is it lumbar spine?
- Is it sacrum or pelvis?
- Is it lower extremity?
  - If STFBT > than SIFBT = lower extremity
  - If SIFBT > than STFBT = lumbar, sacrum or pelvis
    - (R/O lumbar or S/IJ)
  - Pelvis Rx sequence (Mitchell axis model)
    - Up/down shears
    - Pubes dysfunctions
  - Sacrum: if \(L_5\) is out of pattern, treat it before sacrum; then sacrum
    - Innominate rotations
  - **NOTE:** guidelines, not fixed laws

Osteopathic Problem solving:
Screening exam findings

Rescreen & Rx
- 2\(^{nd}\) AGR-H
- 3\(^{rd}\) AGR-H

Complex, inter-woven multi-system Triune patient
PROBLEM SOLVING SCREENING FINDINGS

- **FIRST QUESTION:** IS AGR IN UPPER OR LOWER HALF OF BODY? (T₁₂ REFERENCE POINT)

  - **UPPER HALF PROBLEM SOLVING**
    - IS IT CERVICAL, THORACIC, RIB CAGE OR UPPER EXTREMEITY?
      - **IF CERVICAL**
        - O/A REGION?
          - MUSCULAR . . . O/A, A/A OR BOTH
        - DURAL . . . CRANIAL . . . SCREEN IT OUT AND FIND AGR / SUTURE
      - **TYPICAL CERVICAL . . . FIND AGR, DIAGNOSE AND TREAT**
      - **USE TECHNIQUE APPROPRIATE FOR THAT RESTRICTIVE BARRIER**
    - **IF THORACIC AREA . . . FIND AGR (MAYBE MORE THAN ONE . . . Dx HARDEST END-FEEL)**
      - GETS MORE RESTRICTED AS PALPATE LATERALLY ALONG RELATED RIB = RIB CAGE IS KEY S/D-H
        - EXAMINE RIB CAGE AND IDENTIFY KEY RIB OF DYSFUNCTIONAL PATTERNS
        - TREAT WITH TECHNIQUE APPROPRIATE FOR THAT RESTRICTIVE BARRIER
      - GETS LESS RESTRICTED AS PALPATE LATERALLY ALONG RELATED RIB = VERTEBRA IS THE KEY S/D-H
        - DIAGNOSE DYSFUNCTION
        - TREAT WITH APPROPRIATE TECHNIQUE
    - **IF UPPER EXTREMEITY:** IF YOU IDENTIFY A UNILATERAL BAND OF RESTRICTION ALONG THE WHOLE MEDIAL BORDER OF ONE SCAPULA, THE AGR CAN BE IN:
      - S/C
      - A/C
      - RADIAL HEAD
      - WRIST
      - HAND . . . REMEMBER THE HOMUNCULUS
      - MULTIPLE S/D-H? TREAT MOST RESTRICTED! (FREQUENTLY OTHERS WILL ALSO RESOLVE)
PROBLEM SOLVING SCREENING FINDINGS

- **FIRST QUESTION:** IS AGR IN UPPER OR LOWER HALF OF BODY? (T₁₂ REFERENCE POINT)

- **LOWER HALF PROBLEM SOLVING**
  - **FORWARD BENDING TESTS** . . . FINDINGS CORRELATE WHEN TREATED IN THE PATIENT SPECIFIC SEQUENCE (VLEEMING, FRYER, ETC. BOTH RIGHT AND WRONG)
  - **IF STANDING FORWARD BENDING TEST** IS MORE DRAMATIC THAN SITTING FORWARD BENDING TEST:
    - AGR IS USUALLY IN LEGS . . . USUALLY AGR IS BELOW KNEE
      - FIBULA: PROXIMAL OR DISTAL
      - TIBIAL ROTATION
      - FOOT OR ANKLE
    - OCCASIONALLY IT IS AN UP OR DOWN SHEARED INNOMINATE
    - IF THAT DOESN’T RESOLVE PATTERN . . . BALANCE HIP RESTRICTORS
  - USUALLY WILL ALSO HAVE A UNILATERAL BAND OF RESTRICTION ALONG THE IPSILATERAL LUMBAR SPINE
  - **IF THE SITTING FORWARD BENDING TEST** IS MORE DRAMATIC THAN THE STANDING FORWARD BENDING TEST, IT IS USUALLY EITHER:
    - LUMBAR
    - SACRUM AND / OR INNOMINATE (ROTATIONAL DYSFUNCTIONS)
  - WHEN COME BACK UP AFTER DOING THE SITTING FORWARD BENDING TEST, RE-SCREEN OVER LUMBAR AND S/IJ REGIONS:
    - IF AGR IN LUMBAR . . . DIAGNOSE AND TREAT LUMBAR S/D-H
    - IF THE AGR IS IN PELVIS, USE FOLLOWING SEQUENCE (AXES SIGNIFICANCE)
      - UP / DOWN SHEARS - INNOMINATE: DISRUPT ALL 3 TRANSVERSE EXES
      - CEPHLAD / CAUDAD PUBES . . . LEG LENGTH CHANCE?
      - OUT OF PATTERN L₅ DYSFUNCTIONS WITH SACRAL DIAGNOSIS
      - SACRAL DYSFUNCTIONS . . . ONCE TREATED, AXES LINED UP
      - INNOMINATE ROTATIONAL DYSFUNCTIONS . . . EASY TO TREAT NOW

Note: guidelines, not fixed rules
# A.G.R. / SEQUENCING : issues

<table>
<thead>
<tr>
<th>Know in patient sequence</th>
<th>Suspect not in patient sequence</th>
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| • when treat 1\(^{st}\) A.G.R., multiple areas improve  
  • When diagnose A.G.R., the findings match the descriptions (especially with sacrum)  
  • It is easy to properly position, for either direct or indirect technique selected.  
  • Treatments are effortless  
  • Honors both the complexity and uniqueness of each patient.  
  • Patient realizes you are uniquely treating them | • when treat the 1\(^{st}\) “A.G.R.” there is minimal improvement plus other areas don’t improve  
  • Analogy: like swimming in peanut butter rather than water.  
  • It difficult to properly position the S/D for treatment.  
  • Treatments require a lot of effort  
  • Don’t realize much improvement |
SEQUENCING PRINCIPLES:
Mitchell loved analogies

- EACH PATIENT IS UNIQUE!
  - SNOWFLAKES
  - FIELD OF WALLS

- WOODEN RECORDER:
  - 3 EXAMPLES
    - CAN'T "COOKBOOK" OMT / TECHNIQUE
      - KORR: "YOU CAN HAVE 100 PATIENTS WITH THE SAME DIAGNOSIS BUT REMEMBER THEY ALL GOT THERE BY A DIFFERENT (UNIQUE) ROUTE"
PEELING AN ONION:
- Can’t peel from inside out
- Can’t start between outside and core and peel in either direction
- Must start on the outside and peel layer by layer down to the center or core

NATURAL EXAMPLES OF SEQUENCE IMPORTANCE:
- Growth is sequencial
- Learning is sequencial
- DNA is sequencial

RAY SICARD, PhD

QUESTION:
Is sequencing the language of or management strategy recognized by nature?
SITTING MODELS:
• POSTURAL
• PODIATRY
• TMJ
• CV / RESP
• AGR / SEQ

THEN CAN EXPLAIN

# 1 FRS L
INSP.
R 1-9 INSPIRATION

L/R TORSION

APPRÀISAL:

PLAN: OMT □
Freq.: □
Exercise:

INSTRUCTIONS □
Duration: □
Other:

ATM □
RTN □
FRTW:

PROGNOSIS: E □ G □ F □
P □ U □
SITTING MODELS:
• POSTURAL
• PODIATRY
• TMJ
• CV / RESP
• AGR / SEQ

THEN CAN EXPLAIN

CRANIAL PATTERN
MAY BE ‘SECONDARY’
TO THIS S/D PATTERN

# 1: CAUSE FLAT / Tx LUMBARS 2d TO FRS
• Tx LUMBARS INHIBIT ABDOMINALS?
  • CAUSE HEAD FORWARD
• # 2: CAUSE HIGH L. SHOULDER
• # 3: CAUSE LOW L. SACRAL BASE
  • CAUSES FLAT LUMBAR AREA
  • CAUSE SHORT L. LEG / LOW S.B.
  • CAUSE SCOLIOSIS
• # 4: CAUSE LONG RIGHT LEG
  • AGGREGATE LOW L. SACRAL BASE
• # 5: INTRODUCE CRANIAL ADAPTATIONS
  • CRANIAL S/D . . . WANT TO TREAT 1ST?
Operative MODEL: CV/RESP