

The tension between traditional and modern frameworks

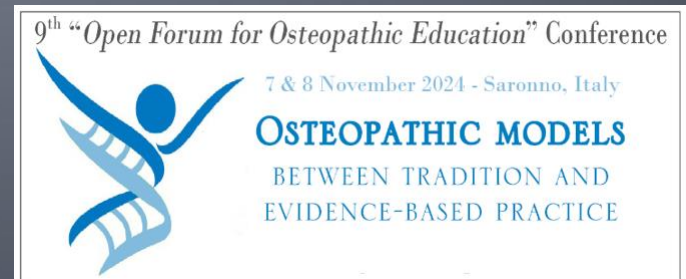
Navigating the clash of competing models for osteopathy

Associate Professor Gary Fryer

Ph.D., B.Sc.(Osteopathy), N.D.

Associate Professor, Victoria University, Melbourne, Australia

*Research Associate Professor, A.T. Still Research Institute,
Kirksville, MO*



This presentation

1. Tension between traditional and progressive models

2. Osteopathy and the health landscape is changing

- Osteopathic models
- Osteopathic identity
- The public health landscape
- Post-professional era?

3. How might we navigate this tension?

4. An example: a student diagnostic formulation model



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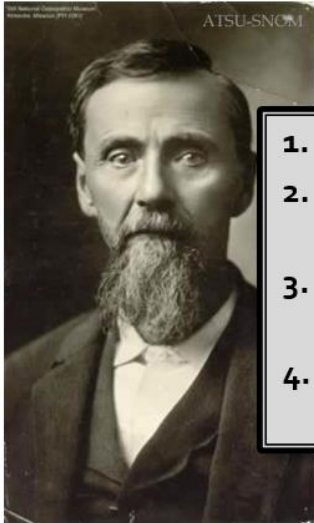
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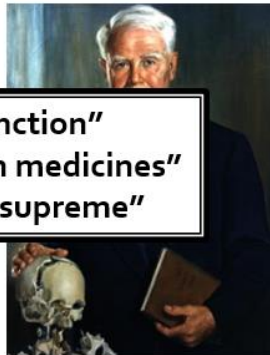
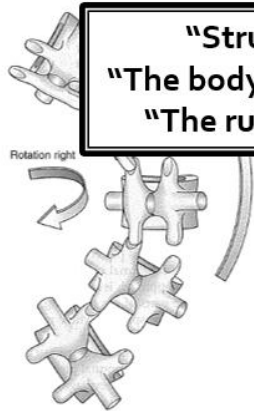


Tension between 'traditionalists' & 'progressives'



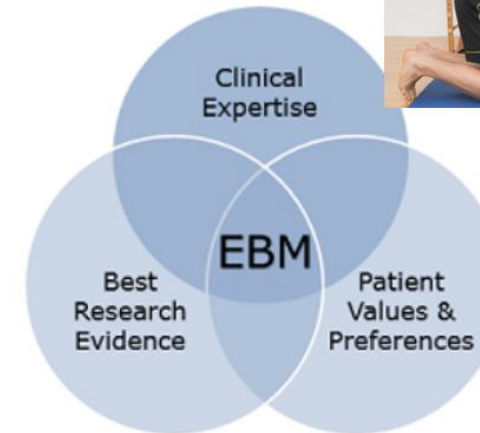
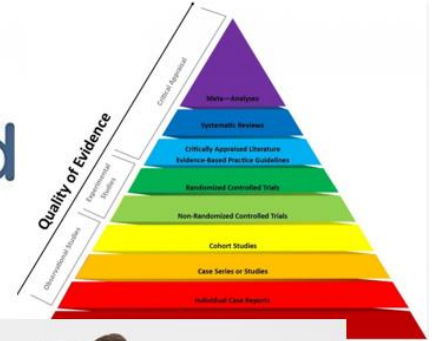
1. The body is a unit
2. Structure and function are reciprocally inter-related
3. The body possesses self-regulatory mechanisms
4. Rational treatment is based on the previous principles

"Structure governs function"
"The body produces its own medicines"
"The rule of the artery is supreme"

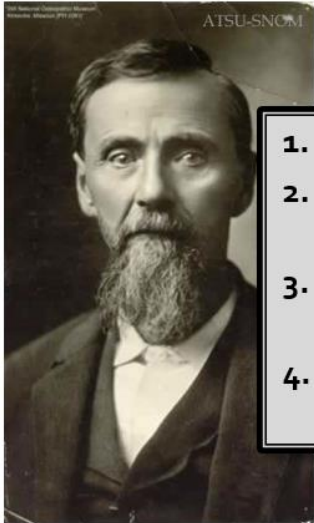


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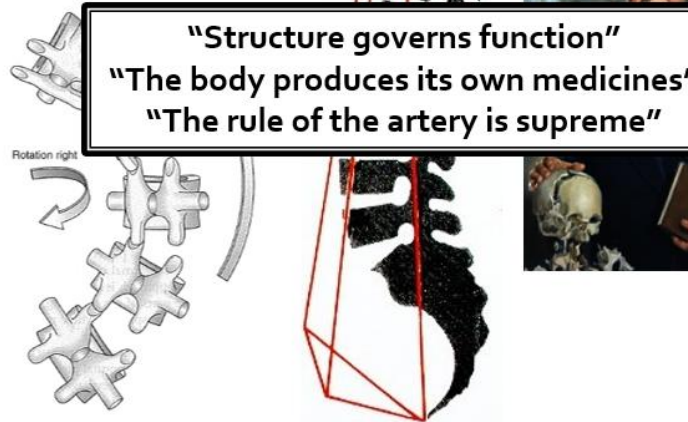
Evidence-Based
Medicine



Tension between 'traditionalists' & 'progressives'



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Tension between 'traditionalists' & 'progressives'

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From distinct to indistinct, the life cycle of a medical heresy. Is osteopathic distinctiveness an anachronism?

Maurice Christopher McGrath
Pages 54-61

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Tension between 'traditionalists' & 'progressives'



International

journal

W(h)ither osteopathy: A call for reflection

The editorial team at The International Journal of Osteopathic Medicine (IJOM) have been discussing the focus of the journal. Many ideas have been put forward including as biopsychosocial osteopathic practice, mechanisms of osteopathy and models of osteopathic care. I also had a conversation with Professor Stephen Tyreman about guest editing another special issue of IJOM before his untimely death. I decided to focus this special issue on the identity and future of osteopathy, drawing on some of Stephen's unpublished writing which he urged me to publish in his last days. I very much hope that the osteopathic community will respond to the call and submit papers to the forthcoming issue, publishing either towards the end of 2022 or in the first issue of 2023. I welcome papers that address one or more of the questions raised in the call/editorial.

There is much happening in osteopathy at the present time. In regulation and education osteopathy is a growing world with all the scrutiny and accountability that entails. Across Europe, governments are gradually recognising



ELSEVIER

International Journal of Osteopathic Medicine 48 (2023) 100659

Contents lists available at ScienceDirect

International Journal of Osteopathic Medicine

journal homepage: www.elsevier.com/locate/ijom

Commentary

What's wrong with osteopathy?

Oliver P. Thomson ^{a,*}, Andrew MacMillan ^{a,b}

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^b School of Education and Sociology, University of Portsmouth, St George's Building, 141 High Street, Portsmouth, PO1 2HY, UK

ARTICLE INFO

Keywords:

Osteopathic medicine
Musculoskeletal manipulations
Professional identity
Manual therapy
Manipulative therapies



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journal homepage: www.elsevier.com/locate/ijom

Pseudoscience: A skeleton in osteopathy's closet?



International Journal of Osteopathic Medicine 52 (2024) 100718

Contents lists available at ScienceDirect

International Journal of Osteopathic Medicine

journal homepage: www.elsevier.com/locate/ijom



ELSEVIER

Commentary

'It's *all* connected, so it *all* matters' - the fallacy of osteopathic anatomical possibilism



(UNED), Spain

Osteopathic theory, practice and identity since the discipline's emergence in the 19th century have been foundational to the present day. The domain of anatomical knowledge has been foundational to justify osteopathic diagnosis, assessment and treatment. Anatomical possibilism refers to the imagined, exaggerated, and often unproven anatomical relationships which are claimed to exist between anatomical structures. In persisting with this practice and reasoning osteopathy may waste time, energy and intellectual resources. It is time to develop more plausible, ethical and person-centred approaches to osteopathy.

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Evolving philosophies and models



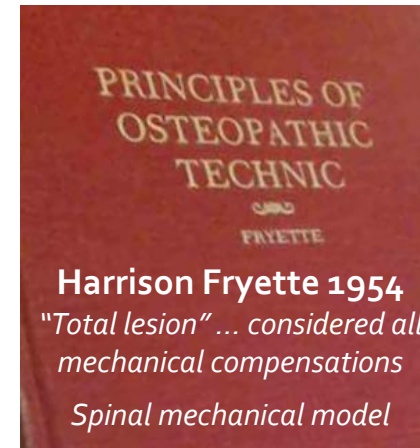
A.T. Still's Platform (1910)

Reference: Still, AT, *Osteopathy: Research & Practice* (1992) pp. 9

1. We believe in sanitation and hygiene
2. We are opposed to the use of serums
3. We oppose vaccinations
4. We accept surgery as a last resort and many surgeries are performed unnecessarily
5. Osteopathy does not depend on electricity, X-ray, hydrotherapy or other adjuncts
6. We have a friendly feeling for other natural therapies. We are opposed to drugs
7. Osteopathy is an independent system and can be applied to all conditions
8. We believe that our therapeutic house is just large enough

A TEXT BOOK
OF
The Principles of Osteopathy
G.D. Hullet 1903
*The osteopathic concept
which is any structural
perversion which by
pressure produces or
maintains functional
disorder*

**Carl P. McConnell
Edythe F. Ashmore
1905-15**
*The lesion involves
histopathological change with
remote effects
Anatomical irregularity of a
joint or spinal articulation*



Harrison Fryette 1954
*"Total lesion" ... considered all
mechanical compensations
Spinal mechanical model*

C.H. Downing 1923
**"Greater Osteopathic Lesion
Complex"**
*...adaptive consequences in the
nervous system, circulatory
system, secretory system, and
excretory system*

J.M. Littlejohn 1908
"Environmental lesion"
*... coupled with mental and psychological
states, health, function, and structure*

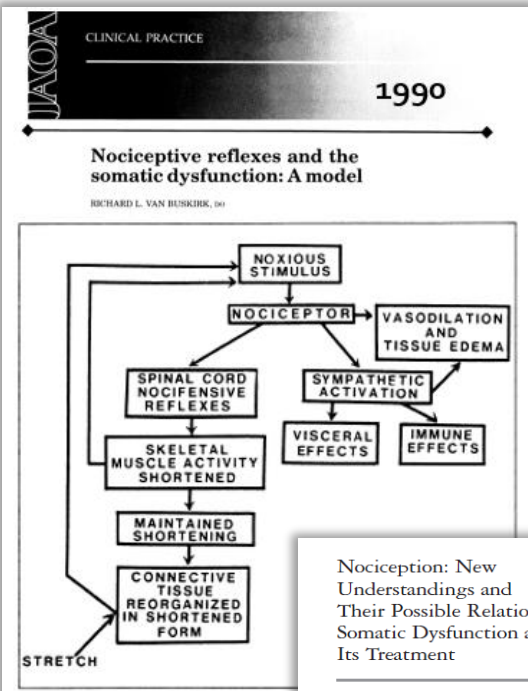
**Select Committee on Osteopathic
Principles & Technique
1953**

1. The body is a unit
2. Structure and function are reciprocally inter-related
3. The body possesses self-regulatory mechanisms
4. Rational treatment is based on the previous principles

**Hospital Assistance Committee of
Academy of Applied Osteopathy
1960s**
"Somatic Dysfunction"



Evolving philosophies and models



Nociception: New Understandings and Their Possible Relation to Somatic Dysfunction and Its Treatment

John N. Howell, PhD
Frank Willard, PhD

Abstract Efforts to explain the underlying pathophysiology of somatic dysfunction have emphasized the role of the somatic and autonomic motor systems. Evidence reviewed here indicates that sensory, dorsal root neurons may also act in a motor fashion to contribute to peripheral changes that may be involved in somatic dysfunction. The peripheral effects of antidromic activity in sensory nociceptive neurons include neurogenic inflammation and may be triggered from peripheral inputs in a reflex fashion called dorsal root reflexes, or by descending activity from portions of the brain known to be activated by parts of the brain which process emotions. These developments may bring a broader perspective to the understanding of the origin of somatic dysfunction.

Key Words somatic dysfunction, dorsal root reflexes, nociception

Special Communication

Australian Journal of Osteopathy 1999

Somatic Dysfunction: updating the concept

Gary Fryer, B.App.Sc(Osteo), N.D.

Introduction

Somatic dysfunction osteopathy philosophy¹. Hypothesis have attempted to dysfunction. It is these concepts as fundamental principle search for more

Originally called somatic dysfunction², "greater osteopathy segmental somatic dysfunction" primarily myofascial paper will focus on which affects a column.

Somatic dysfunction related components

Journal of Osteopathic Medicine, 2003; 6(2): 64-73

© 2003 Research Media

Commentary

Intervertebral dysfunction: a discussion of the manipulable spinal lesion

Fryer, G.

School of Health Sciences, Victoria Univ

Abstract

The concept of the manipulative treatment of the dysfunction is discussed both mechanical and proprioceptive, changes predisposing the segment of manual treatment is research.

International Journal of Osteopathic Medicine (2016) 22, 52–53



MASTERCLASS

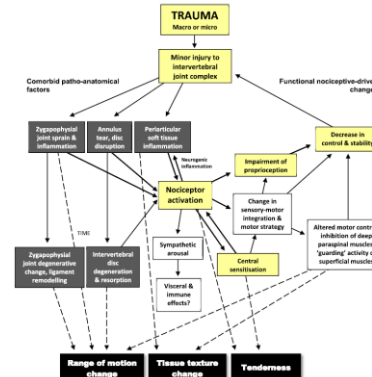
Somatic dysfunction: An osteopathic conundrum

Gary Fryer^{a,b,*}

^a Centre for Chronic Disease Melbourne, Australia
^b A.T. Still Research Institute

Received 19 October 2015; revised

KEYWORDS
Osteopathic medicine;
Diagnosis;
Palpation;
Somatic dysfunction



Journal of Bodywork & Movement Therapies (2015) 19, 310–326



Available online at www.sciencedirect.com

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journal homepage: www.elsevier.com/jbmt



FASCIA SCIENCE AND CLINICAL APPLICATIONS: EXTENSIVE REVIEW

A unifying neuro-fasciogenic model of somatic dysfunction – Underlying mechanisms and treatment – Part I

Paolo Tozzi, MSc Ost, DO, PT

School of Osteopathy C.R.O.M.O.N., Rome, Italy

Received 3 October 2014; received in revised form 6 January 2015; accepted 8 January 2015

KEYWORDS

Fascia;
Somatic dysfunction;
Fascial dysfunction;
Fascial mechanistic;
Osteopathic manipulative treatment;
Osteopathic model;
Fasciogenic model;
Fascial treatment;
Fascial release;
Manual therapy

Journal of Bodywork & Movement Therapies 24 (2020) 181–189



Contents lists available at ScienceDirect
Journal of Bodywork & Movement Therapies

journal homepage: www.elsevier.com/jbmt



Myofascial Pain and Treatment

A new perspective for Somatic Dysfunction in Osteopathy: the Variability Model

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^a SOMA - Istituto Osteopatia Milano, 336 F Sarca Road, 20126 Milan, Italy

^b Division of Neurology and Neurorehabilitation, IRCCS Istituto Auxologico Italiano, 28824 Piacavallo-Verbania, Italy

^c Department of Neuroscience, University of Turin, 10126 Turin, Italy

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Keywords:
Somatic dysfunction
Osteopathy
Palpation
Diagnosis
Physical examination
Variability

ABSTRACT

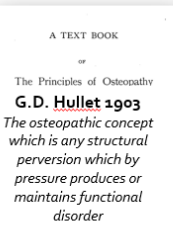
Introduction: Osteopathy uses manipulative techniques to support physiological function and adaptation. These conditions are modified by the presence of Somatic Dysfunction (SD), an altered function of the components of the body's framework system. Despite SD's widespread use in clinical practice and education, research has previously shown poor results in terms of reliability and validity. In this theoretical article, the authors' proposal is to argue for a new clinical perspective for SD, which suggests a different palpatory assessment of its clinical signs: the "Variability Model".
Methods: A double simultaneous literature search was performed between January and March 2019 in Medline's electronic database. The first one critically analysed the clinical signs most used to detect SD. The second one informed authors' hypothesis related to movement variability assessment in the Neutral Zone (NZ).
Discussion: The Variability Model explains how the assessment of the range of motion in the NZ is essential to detect SD, its motion asymmetry and its relative restriction.

Evolving models largely underpinned by evolving research



A.T. Still's Platform (1910)

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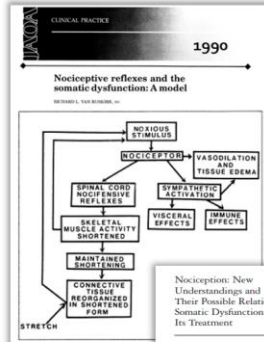
Harrison Fryette 1954
"Total lesion" ... considered all mechanical compensations Spinal mechanical model

C.H. Downing 1923
"Greater Osteopathic Lesion Complex" ... adaptive consequences in the nervous system, circulatory system, secretory system, and excretory system

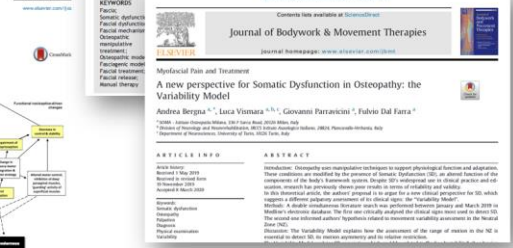
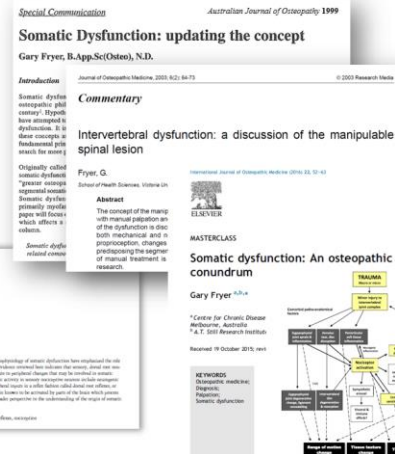
Select Committee on Osteopathic Principles & Technique 1953

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Hospital Assistance Committee of Academy of Applied Osteopathy 1960s
"Somatic Dysfunction"



Nociception: New Understandings and Their Possible Relation to Somatic Dysfunction and Its Treatment
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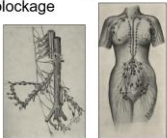
Louisa Burns, D.O., M.S.

- First major contribution to osteopathic research: A.T. Still Research Institute
- 1907 - "Viscero-somatic and somato-visceral spinal reflexes"
- Experimented with the creation of 'osteopathic lesions' in human & animal models
- Published huge volume of work:



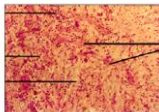
F.P. Millard, D.O.

- Applied Anatomy of the Lymphatics (1922)
- Lymph flow modulated by nodular enlargement and blockage



Wilbur Cole, D.O.

- 1922 - Applied Anatomy of the Lymphatic
- 1952 - Histology studies of osteopathic lesion
- Area of edema & accumulation of WBCs



Kirkville College of Osteopathy & Surgery

First systematic investigation relevant to the 'osteopathic lesion' published in mainstream scientific journals



J. Sted Denslow, D.O.

- Large volume of work from 1941 involving:
- EMG related to osteopathic lesion
- Biomechanics and osteopathic principles

Irvin M. Korr Ph.D.

- Large volume of work from 1947 involving:
- EMG & segmental sympathetic tone related to osteopathic lesion
- Nerve growth factors
- Philosophical papers on OMT



Neurophysiology research

Pain research

Pain research

Central sensitisation

Psychosocial

Fascial research

Mechanotransduction

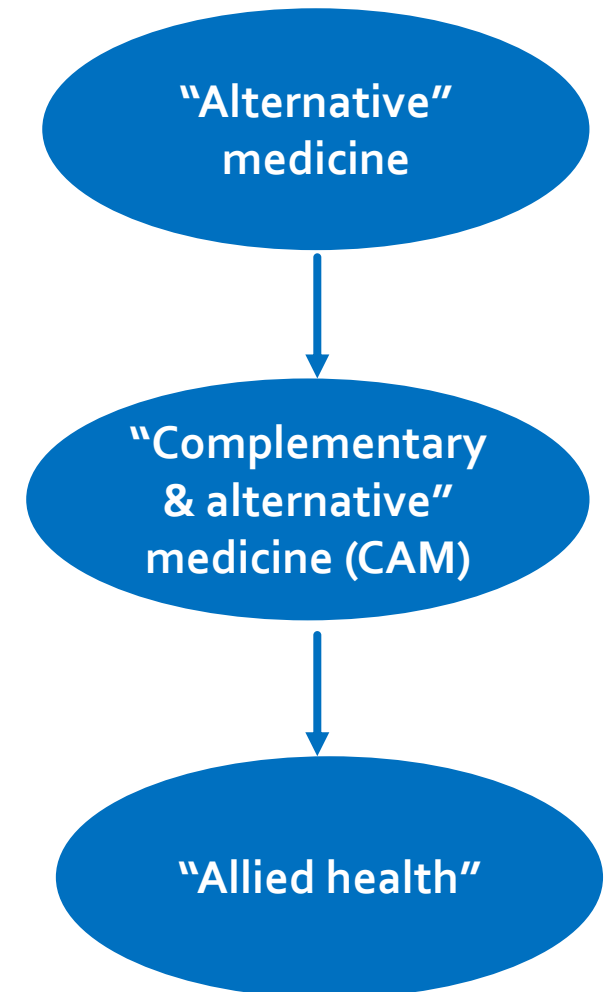
Informed by research from outside the profession

The health landscape is changing

For example, Osteopathy in Australia ...

- Registration since 1979 and university training since 1986
- Most osteopaths now work in **group practices**
- Increasing **collaborative** interprofessional care
- Expectation that osteopaths work within Clinical Guidelines and undertake PROMs for compensable patients
- Graduate **capabilities are broad** and transferable
- Many graduates seeking **non-traditional work settings**

Professional identity is changing



Capabilities for osteopathic practice (2019)



Role	Key capabilities
1. Osteopath	<p>1.1 Practise osteopathy within the accepted scope of practice with diverse population groups across the lifespan.</p> <p>1.2 Apply a patient/client-centred approach to practice.</p> <p>1.3 Plan and implement efficient, effective, culturally safe and patient/client-centred assessments.</p> <p>1.4 Develop management plans based on sound clinical reasoning, scientific evidence and patient/client preferences to inform decision-making.</p> <p>1.5 Implement and review management plans using sound clinical reasoning to facilitate optimal patient/client participation in work and activities of daily living.</p> <p>1.6 Apply knowledge of safe and quality use of medicines to practice.</p>
2. Professional and ethical practitioner	<p>2.1 Comply with legal, professional, ethical and other relevant standards, codes and guidelines.</p> <p>2.2 Make and act on informed and appropriate decisions about acceptable professional and ethical behaviours.</p> <p>2.3 Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of healthcare quality and patient/client safety.</p> <p>2.4 Recognise the need for, and implement, appropriate strategies to manage practitioner self-care.</p> <p>2.5 Advocate for patients/clients.</p>
3. Communicator	<p>3.1 Consider and demonstrate socio-cultural awareness in communication and management.</p> <p>3.2 Communicate effectively on all aspects and through all stages of the care process with patients/clients and relevant others.</p> <p>3.3 Document and appropriately share written and electronic information about patient/clients' care to optimise clinical decision-making, patient/client safety, confidentiality and privacy.</p>

Capabilities for osteopathic practice (2019)



Role	Key capabilities
4. Critical reflective practitioner and lifelong learner	<p>4.1 Evaluate their own practice against relevant professional benchmarks and act to continually improve practice.</p> <p>4.2 Engage in the continuous enhancement of professional activities through ongoing learning.</p> <p>4.3 Integrate the best available evidence into practice.</p> <p>4.4 Contribute to the refinement and dissemination of knowledge and practices applicable to health.</p>
5. Educator and health promoter	<p>5.1 Use education for self-empowerment and to empower others in the practice context.</p> <p>5.2 Demonstrate commitment to the principles of health education; disease prevention; rehabilitation; and amelioration of impairment, disability and limited participation.</p>
6. Collaborative practitioner	<p>6.1 Engage in an inclusive, collaborative, consultative, culturally safe and patient/client-centred model of practice including Aboriginal and Torres Strait Islander peoples.</p> <p>6.2 Work effectively as a member of a diverse, inter-professional healthcare community, including Aboriginal and Torres Strait Islander peoples.</p>
7. Leader and manager	<p>7.1 Lead others effectively and efficiently in relevant professional, ethical and legal frameworks.</p> <p>7.2 Organise and prioritise workload and resources to autonomously provide safe, effective and efficient osteopathic care and where relevant, as a team leader.</p>

Changing practice settings

In Australia, now **most osteopaths (84%) practice in a multi-practitioner location** (Adams et al. 2018)

Many Australian graduates are now finding work in non-traditional osteopathic roles

- Occupational health & rehabilitation
- Aged care
- Disability services (NDIS)
- Community outreach settings
- Workplace assessors
- Treatment in workplace settings

This can only occur if osteopaths have a broad range of competencies to allow for transferable skills



Job search

Profile

Career advice

Company reviews

Sign in

Employer site

What

osteopath



Any Classification



Where

Enter suburb, city, or region

SEEK

All work types



paying \$0



to \$350K+



listed any time



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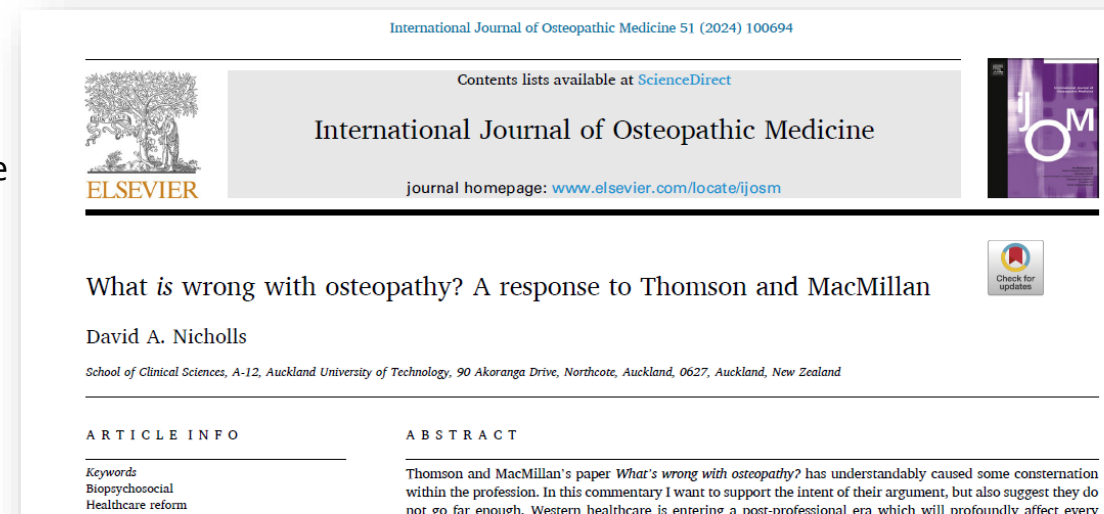
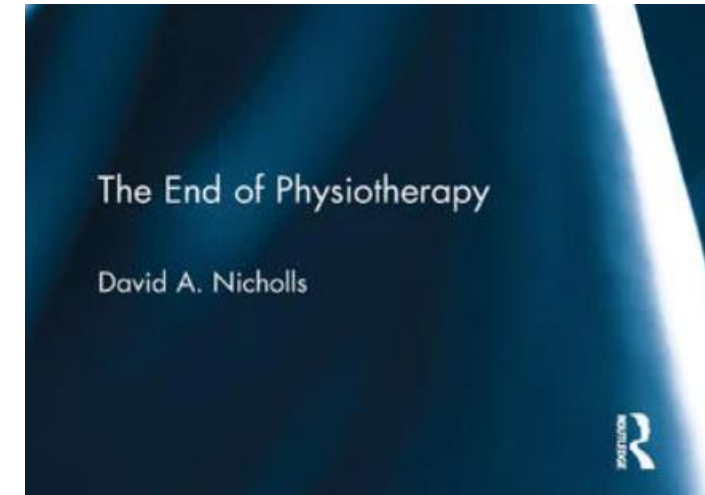
2d ago

More changes ... a post-professional era?

Nicholls (2024) argues that Western healthcare is entering a **post-professional era** which will profoundly affect every profession's identity and social purpose

Challenges such as ...

- Increasing demands for holistic healthcare for **ageing populations of increasingly complex, comorbid, chronically ill** people
- Digital technologies and the rapid **rise of AI** and digital data
- Peoples' appetite for personalised healthcare **demanding more choice**, control & greater flexibility
- The publics' progressive **loss of faith in once powerful authorities**
- The **pressure to remain up-to-date** with the latest evidence-based findings
- The **loss of control of knowledge** that was once 'ours'
- Threats of **encroachment from other professions** looking for competitive advantage
- The **rising cost of healthcare** matched with the desire by governments to cut expenditure
- The rapid **privatisation of health** and the growing gradient between those who can/cannot afford
- The **growing critique of the regulated professions** for their resistance to change
- Problems inherent in being a comparatively **small healthcare workforce**



More changes ... a post-professional era?

Nicholls (2024) outlines four responses:

1. Do nothing

- Watching and waiting to see what emerges from this period of unprecedented disruption

2. Revival of the profession's heritage

- Return to its roots and restate its long fought-for professional identity; specialisation

3. The Renaissance professional

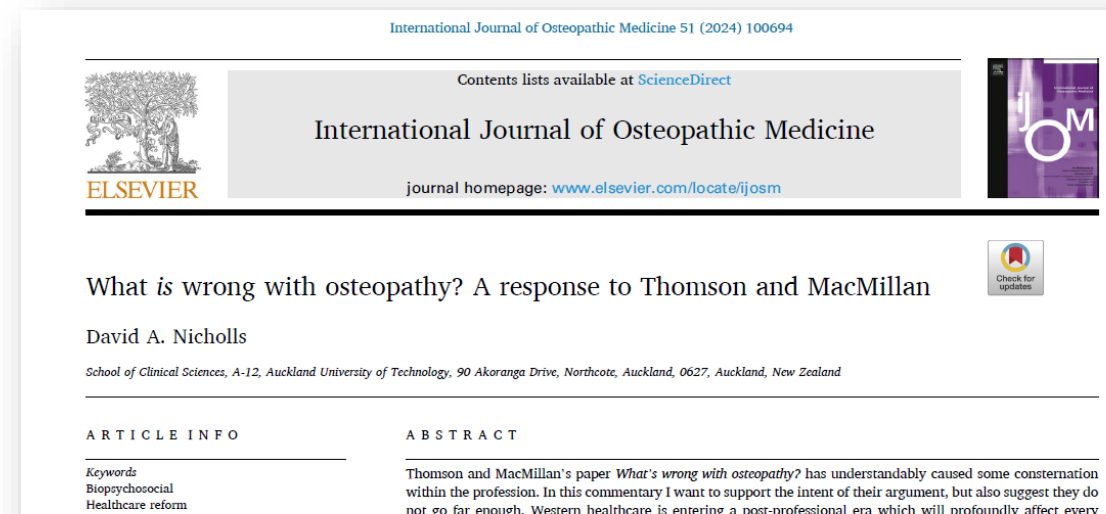
- Begin again with a new model of osteopathy

4. The 'Hybrid approach'

- Take the best of the old and blend it with the best of the new

Nicholls argues all 4 responses are flawed

He suggests that the problem lies in the assumption that the goal is to preserve osteopathy as a profession



This presentation

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- Osteopathic models
- Osteopathic identity
- The public health landscape
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3. How might we navigate this tension?

4. An example: a student diagnostic formulation model



How do we navigate this tension?

1. Accept that *everything* changes

Has there always been this tension?
YES!

Even in the **early 20th Century**, there was ongoing tension and bitter debate between Broad and Lesionist factions

Due to constant pressure and criticism, the AOA made a resolution in **1929** for pharmacology to be “permissible” (Gevitz 1982)



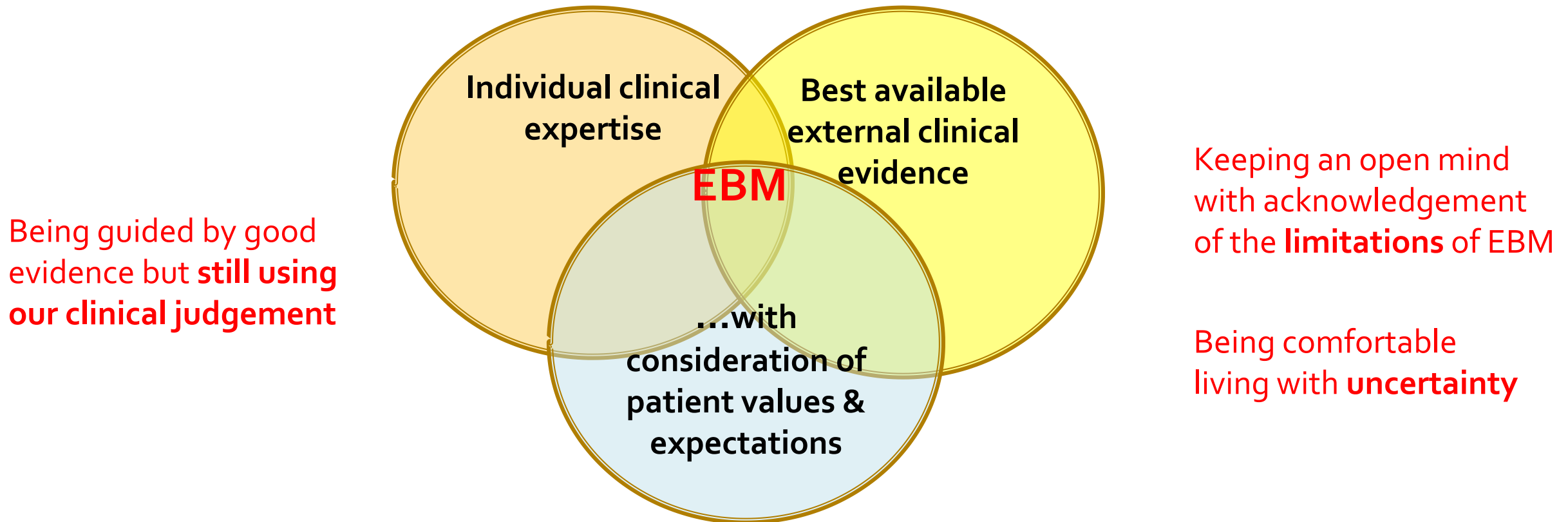
"Keep it pure, boys, keep it pure"

How might we navigate this tension?

1. Accept that *everything* changes
2. **Be willing to change when there is good evidence to do so**

Evidence-Based Medicine (EBM)

“Evidence-based medicine is the integration of best *research evidence* with *clinical expertise* and *patient values*”(Sackett 1996)



Osteopaths have a positive attitude towards EBP

- Australian, UK & Swedish osteopaths have a **positive view towards EBP**
 - But they appear to **overestimate their skills** in EBP (relative to their reported use of EBP)
 - Lack of time & paucity of evidence are perceived barriers
 - Recommendation for further CPD training in EBP

Sundberg et al. *BMC Musculoskeletal Disorders* (2018) 19:439
<https://doi.org/10.1186/s12891-018-2354-6>

RESEARCH ARTICLE

Attitudes, skills and use of evidence-based practice among UK osteopaths: a national cross-sectional survey

Tobias Sundberg^{1,2}, Matthew J. Leach^{1,3}, Oliver P. Thomson^{4,5}, Philip Austin⁶, Gary Fryer^{7*}

Abstract

Background: Evidence-based practice (EBP) is a clinical decision-making framework that supports improvement in healthcare. While osteopaths are key providers of musculoskeletal healthcare, the extent to which osteopaths engage in EBP is unclear. Thus, the aim of this cross-sectional study was to investigate attitudes, skills and use of EBP, and perceived barriers and facilitators of EBP uptake.

Methods: UK-registered osteopaths were invited to complete the Evidence-Based Practice Attitudes Survey (EBASE) online.

Leach et al. *BMC Health Services Research* (2019) 19:498
<https://doi.org/10.1186/s12913-019-4329-1>

BMC Health Services Research

RESEARCH ARTICLE

An investigation of Australian osteopaths' attitudes, skills and utilisation of evidence-based practice: a national cross-sectional survey

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Abstract

Background: Osteopaths are an integral member of the health care team, playing a pivotal role for patients with musculoskeletal disorders. Osteopaths, like other health care providers, face pressure to deliver evidence-based health care and to improve patient outcomes. However, the extent to which osteopaths engage in evidence-based practice (EBP), particularly in Australia, is not clear. This study therefore set out to investigate the attitudes, skills and use of EBP, and perceived enablers of EBP uptake, among osteopaths practicing in Australia.

Methods: National cross-sectional survey of Australian registered osteopaths. Eligible participants were invited to complete the Evidence-Based Practice Attitudes Survey (EBASE) online.

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Attitudes, skills, and use of evidence-based practice: A cross-sectional survey of Swedish osteopaths

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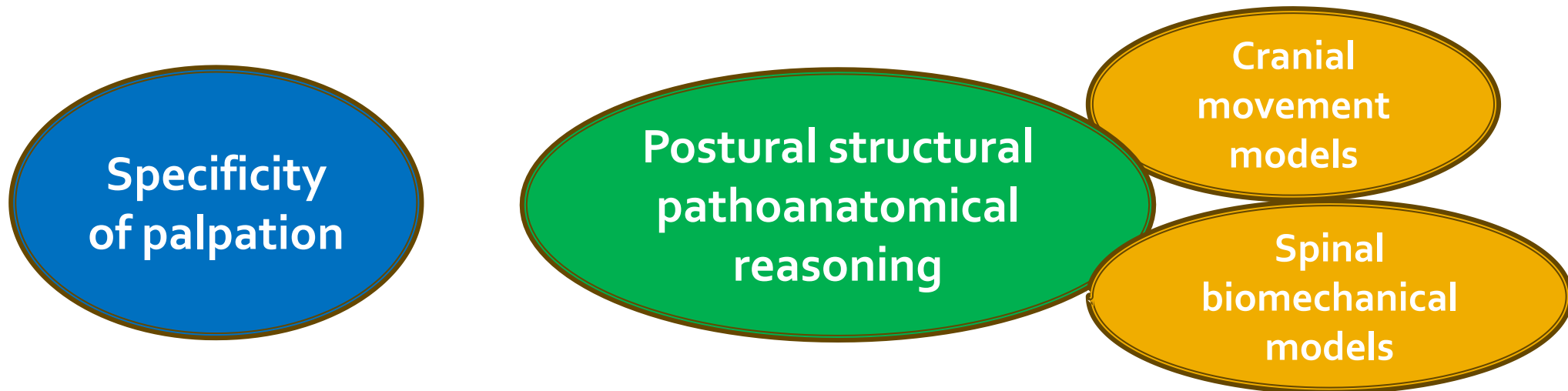
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How might we navigate this tension?

1. Accept that *everything* changes
2. Be willing to change when there is good evidence to do so

This includes abandoning models and beliefs which are clearly inconsistent with evidence and/or lack plausible mechanisms



How do we navigate this tension?

1. Accept that *everything* changes
2. Be prepared to change when there is good evidence to do so
3. **Recognise the commonalities within the profession**

There are things we likely agree on...

'Holistic' interconnectedness of the body

(physically, socially, environmentally; BPS)

Importance of manual therapy

Role in health promotion

Spending time with the patient

Will assist with...

Professional identity?

Osteopathic distinctiveness?

This presentation

1. Tension between traditional and progressive models

2. Osteopathy and the health landscape is changing

- Osteopathic models
- Osteopathic identity
- The public health landscape
- Post-professional era?

3. How might we navigate this tension?

4. An example: a student diagnostic formulation model



Limitations with older diagnostic models

1. A tissue-based diagnosis was not always appropriate

- Nonspecific or 'mechanical' back pain
- Chronic pain

"Facet sprain of L3/4"

"Somatic dysfunction of L4/5"

2. Diagnosis should reflect the growing importance of

- Pain processes
- Psychosocial factors

*Nociceptive
Nociplastic
Neuropathic*

3. Diagnosis needs to be readily understood by other health professionals and third parties (interprofessional communication)

- Medical practitioners
- Other allied health practitioners
- Third party insurers

*Yellow flags
Patient self-efficacy*

The VU Diagnostic Model

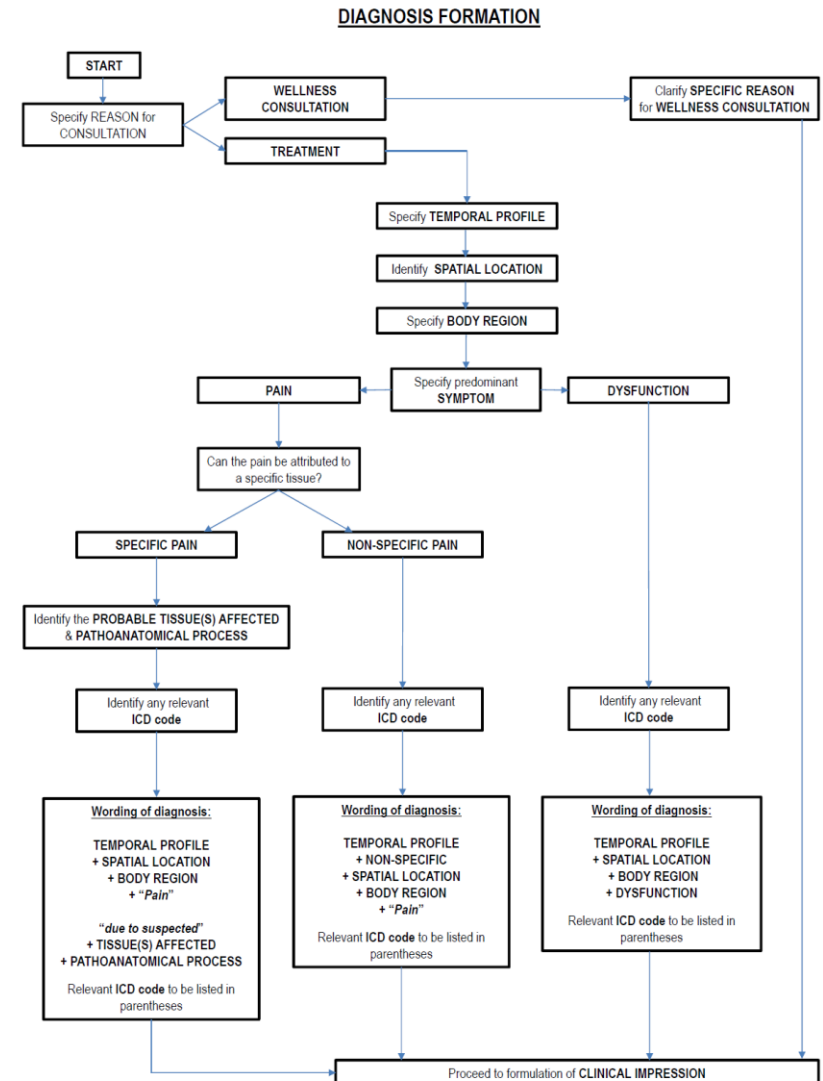
Two components of new model:

1. Diagnosis

- Brief, standard nomenclature (where possible)

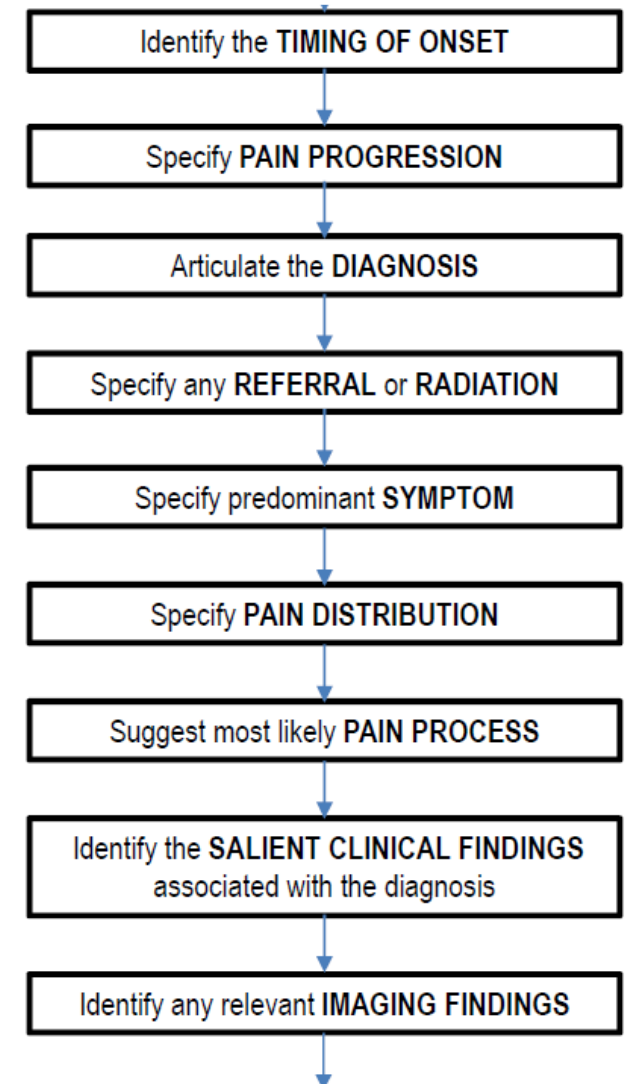
2. Clinical impression

- Narrative description, which includes
 - Likely pain process
 - Pathological factors and/or
 - Biomechanical factors and/or
 - Psychosocial factors



2. Clinical Impression formulation

- **Short narrative overview** of patient
 - Summary of the patient presentation & overall impression in prose
 - Allows the **reader to understand the emphasis and context** of contributing factors
 - Components can be varied according the case
- Includes the following elements
 - **Likely pain process**
 - **Pathological factors**
 - **Biomechanical (osteopathic) factors**
 - **Psychosocial factors**



Clinical Impression formulation

Wording of clinical impression (TREATMENT):

[name] is a [age] year old [gender] [occupation] presenting with a [timing of onset] duration of [pain progression] [diagnosis] with [referral / radiation]. [name]'s [symptom] is [pain distribution] and likely [pain process] in nature. [name] also displayed [salient clinical findings]. [name]'s complaint is [likely/confirmed] due to [imaging findings], predisposed by [pathological factors AND/OR biomechanical factors AND/OR psychosocial factors] and maintained by [pathological factors AND/OR biomechanical factors AND/OR psychosocial factors].

Amanda is a **54** year old **female landscape gardener** presenting with **chronic progressive nonspecific neck pain with referral to the right scapular and upper arm**. Amanda's pain is multifocal and likely a mix of nociceptive and nociplastic in nature, with referred nociceptive pain from suspected lower cervical facet joints. Amanda displays **marked tenderness over her right rhomboid and trapezius muscles**. Amanda's complaint is likely unrelated to the minor cervical degenerative changes seen on X-ray. Her relatively **increased and inflexible thoracic kyphosis** and resultant head forward posture may predispose and contribute to mechanical strain and irritability of the lower cervical spine. Amanda demonstrates **substantial misinterpretation of her neck pain and catastrophises** about it, which likely exacerbates her pain and guarding behaviour.

The VU Diagnostic Model

Two components of new model:

1. Diagnosis

- Brief, standard nomenclature (where possible)

An attempt to use standard medical terminology
for optimal interprofessional communication

AND

2. Clinical impression

- Narrative description, which includes
 - Likely pain process
 - Pathological factors and/or
 - Biomechanical factors and/or
 - Psychosocial factors

elucidating the most important patient contextual
factors including pain process, psychosocial and
osteopathic factors



1. Tension between traditional and progressive models

Summary

2. Osteopathy and the health landscape is changing

Always been this way ...

- Osteopathic models
- Osteopathic identity
- The public health landscape
- Post-professional era?

3. How might we navigate this tension?

1. Accept that *everything* changes; live with uncertainty
2. Be prepared to change when there is good evidence to do so
3. Recognise the commonalities within the profession

4. An example: a student diagnostic formulation model

The tension between traditional and modern frameworks

Navigating the clash of competing models for osteopathy

THANKYOU

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