SOTO AUSTRALASIA

WINTER 2008

EXPRESSION

CATEGORY SEVEN – THE OBLIQUE SACRUM

It would be a fairly correct statement that most chiropractors check leg length as an indication of spinal and pelvic balance. It is also noted that chiropractors are not the only profession concerned with this problem. However, chiropractors are in the unique position of being able to assess the effect that spinal and pelvic misalignment has on leg length and what effect leg length has on spinal and pelvic balance.

Historically, our profession has used the terms *true short leg* and *functional short leg*. The true short leg or anatomical short leg is that person who has been born with a height imbalance from femur to calcaneous or who has acquired a short leg from fracture, injury or disease. The functional short leg is a unique focus of chiropractors as this is the leg differential produced by pelvic rotation, lumbar spine misalignment, diaphragm contracture and/or upper cervical subluxation.

DeJarnette discussed the problems of the deficient extremity in the 1970 SOT manual which he classified as Category Seven in that year's eight category system[1]. The questions which are posed in short leg analysis and correction are: does this person have a true short leg or a functional short leg? If they do have a true short leg what do I do – add a shoe lift, a heel lift, or sole lift? For that matter, can a lift temporarily help a functional short leg? If a lift is to be placed, what amount and for how long?

In SOT terms, we are dealing within our framework with the question of, "how does the presence of a true short leg affect our categories I, II, and III?"

Analytical Methods

DeJarnette's position statement from the 1970 notes[2,3] was that: "extremity inequality means that normal skeletal balance and function are not possible. If left unsolved, the patient fails to recover." And further: "The short leg is a cause of many musculoskeletal problems as well as the cause of many visceral problems. A continuous short leg problem can lead to severe cardiac problems and circulatory failure. The diaphragm must be balanced to function. It cannot be balanced if the pelvis is under a constant stress due to this extremity deficiency."

DeJarnette showed caution in using a lift when he wrote[4]: "it is erroneous to substitute a lift for a corrective adjustment when that adjustment is specifically indicated." And emphasized the fact that you had to make sure that you did, indeed, have a true short leg before you, in his words[5], "condemned a patient to a lifetime of a built-up shoe and not walking without wearing these shoes."

Apart from using a tape measure, which has limitations, there are the two main methods which have been used in chiropractic to determine true short leg measurement and its biomechanical effect – visual analysis and x-ray analysis. Let's look at each.

Visual Analysis

DeJarnette's Distortion Analyser is a good place to start in the search for an existing leg deficiency. We know that a functional short leg as found with the categories gives us a lateral sway, an A-P sway or an antalgia, but the true short leg, when present, gives a different manifestation. Visual analysis with the true short leg has the plumbline bisecting the sacrum, placing the base on one side and the apex on the opposite side – thus we get the term "oblique sacrum."

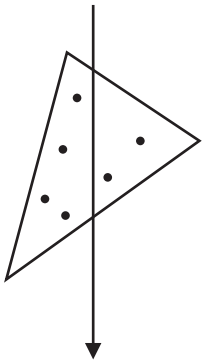


Diagram 1

There are, in fact, three other measurements the true short leg will exhibit. First, there will be a low hip and pelvis in standing position and this can be measured by thumb over the top of the crest comparison. Of course, this measurement can be a difficulty with the obese patient.

Second, in the prone position, by leg stretch and malleoli comparison there will be a short leg on the same side as the low hip in the upright position and last, the supine leg check position must agree with the upright and prone positions and yet, with the four factors mentioned – oblique sacrum cutting the plumbline, pelvic height, prone & supine leg checks – it is still good to have x-ray verification.

At this stage of the discussion you are probably thinking about the interplay between true short leg and functional short leg. We know we were!

Article continued on Page 2

INSIDE THIS ISSUE:

EDITOR:

Darren Little

SURRY HILLS, SYDNEY

(02) 9698 0007

darren@

centraltohealth.com.au

PRESIDENT'S REPORT – DR BRETT HOULDEN

Hello to all, great to be able to chat with you once again. Your organisation continues to purr along as we were chatting about at our board meeting recently.

Our research fund continues to grow its balance, so if you have a worthy idea or thought that needs investigating and you have a desire to do some research, chat with us. I believe research is a big part of what we need to continue to develop, for ourselves, and for our profession. I suggest that if you do not wish to do the research, you donate some cash regularly to the fund so that others that have the inkling and the time to do something have the finances to do it appropriately and well. Donate a patient a week, or something as minor as that, and if we all did this, over 200 members, $40 a week, that is $8,000 a week, or a staggering $416,000 a year that could go into our research. What have you done lately to further that profession which continues to give you your livelihood???

I love SOT so much, and I would love to see much more research on how well many of the little things we do create such great results with such gentle force, wouldn't you?

We also need to have more people proficient in SOT as well, if you have not thought about witting your proficiency exam, it is a great way to make sure you know your stuff, and I bet more experienced SOT doctors will then refer their patients to you. It is the first thing I look for in the directory prior to referring, have you got a thorough knowledge so I can confidently tell my patient that you will look after them? Also, if you sit your proficiency, you are invited to assist at our basic series, for which you no longer have to pay for! What a bonus.

Yours in SOT, Brett Houlden

CATEGORY SEVEN – THE OBLIQUE SACRUM cont'd...

By this, we mean to answer the question of what is underlying that true short leg; the patient is still category I, II, or III along with their Category VII.

This is best expressed in diagram form.

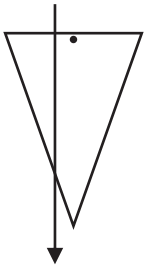


Diagram 2

Gravity Line to Left of Centre

This pelvis has moved laterally to the right. This occurs and is definitive of a sacroiliac slip separation. You can experiment with the posture by pushing the patient's pelvis to the left, as far as you like, it will still come back and settle in the right-of-centre position.

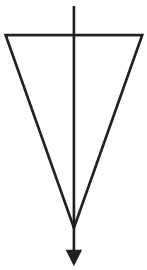


Diagram 3

Lumbar Spine on the Line

This pelvis is sacrum near the centre and vertical. This is a sacroiliac boot subluxation. It is not weight-bearing so does not produce lateral movement.

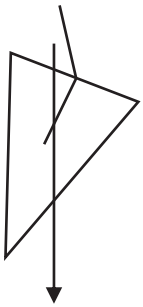


Diagram 4

The Oblique Sacrum

This is the oblique pelvis which is always associated with anomalies or deficient leg. Always do an upright pelvic film to verify.

In diagrams 2, 3 and 4 we can see the differences but now for some combinations and some DeJarnette practicality[6].

A heel and sole lift is made up for testing purposes, consisting of a left 9mm heel, 6mm sole then turn it upside down and it's a right 9mm heel, 6mm sole (DeJarnette suggested an heel and sole lift – these have gone out of fashion as has the boot maker, so it has got us wondering what effect it would have now that people use heel lifts only; research project!). You can make the lift out of your choice of material be it leather, rubber or cardboard.

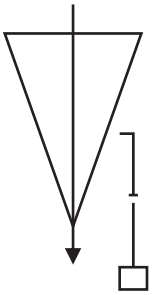


Diagram 5

An oblique sacrum with base right and apex left. Right heel and sole lift placement stabilizes the pelvis and gives us a Category I patient for block technique.

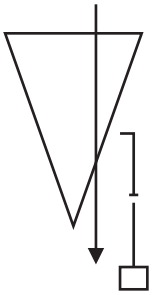


Diagram 6

This was also an oblique sacrum with base right and apex left. Heel and sole lift to the right produces a left shift of the total pelvis.

This gives us a Category II patient.

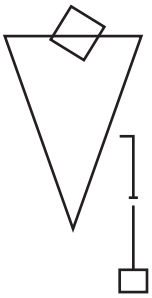


Diagram 7

This is an oblique sacrum with heel and sole lift and a left sciatica of many weeks duration. The right heel and sole lift produces a fifth lumbar right inferior. Adjust as a right inferior with total relief of left sciatica.

X-Ray Analysis

DeJarnette favoured the sectional 14x17 inch film with the focal spot at the acetabular head line for gaining an estimate of leg imbalance[7] (as opposed to the 14x36 full spine radiograph). The key word is "estimate" as there are the factors of parallax error, patient placement fault and the loss of imaging that goes with transforming a 3D object onto a 2D image.

Article continued on Page 4

FROM THE EDITOR'S PEN

Dear SOT colleagues,

I encourage everyone to become actively involved in the organization as much as you can, for it will help aid us in supporting you in practice and strengthen SOT within chiropractic in Australia. Whether it be attending seminars, feedback on the new website, table educating or letters of interest for the newsletter it all helps to make our organization grounded, on the right track for our members and improving.

Thanks again must go to the Kyneur brothers for their effort in producing the Category Series articles over the last 12 months. A special mention also to Keith Bastian for his historic recollection of SOT in Australia. See you all in steamy Cairns in November at the AGM and Annual Convention.

Darren

Mark this on your calendar now! A must for all those treating pregnant patients!!!

Functional Pregnancy

Termed, functional pregnancy, this intensive weekend offers comprehensive training for managing the pregnant patient.

Beginning with pre-conception issues, Dr. Seekins demonstrates treatments for and discusses the three trimesters of gestation, concluding with post-partum complications and recommendations.

You will be taught manual, SOT-based, adjusting techniques specifically useful for gravid patients, nutrition, folk remedies, lifestyle recommendations and exercises – all clinically tested and sound for your pregnant patients.

Gathered from eighteen years of clinical, personal experience and home-birthing four children of her own, Dr. Seekins has created a comprehensive, unique, **useful and fun curriculum** for this weekend.

Dr. Suzanne Seekins graduated from Logan College of Chiropractic in 1990. She spent the first seven years of practice being mentored by world renowned Craniopath, Dr. Joseph Unger in St Louis, Missouri.

Now a post-graduate faculty member teaching on pregnancy Craniopathy and paediatrics, Dr. Seekins taught SOT at Logan College for 5 years. She served as co-director of an outpatient facility, and clinician, all while maintaining her private practice in St Louis.

Dr. Seekins is the mother of four healthy, vibrant and home-birthed children. She is a Certified Craniopath, a member at Who's Who in American Colleges, and President Emeritus at SORSI. She frequently hosts in her office student doctors during their preceptor ship from Logan and Palmer Colleges. It is her greatest pleasure to teach SOT.

Her motto,

"Don't be afraid of the belly!"

Bring along your partners and/or your CA's for a CA Module which will be part of our weekend (More details to come!!). What better place than the beautiful far north Queensland to extend for a well-earned break!

November 1 & 2 2008

Cairns International Hotel, Cairns

www.cairnsinternational.com.au

Earlybird Discount **$50pp** if registered before September 19, 2008

CATEGORY SEVEN – THE OBLIQUE SACRUM cont'd...

DeJarnette summarised: "Empiricism says to x-ray and believe what you see and act according to doctrine. This is perhaps a wise move in 15% of all cases seen, but a foolish move in 85% of your case load."[8]

The sort of contradiction that can occur is when the x-rays show a right deficiency and the patient presents as a left short leg, supine category II.

We have already mentioned DeJarnette's Distortion Analysis and Combination findings so as to differentiate the categories I, II, III from the oblique sacrum, which we could summarize as: look for the functional short leg (categories) and block accordingly. Then, if you do find the true short leg which is not a category I, II or III and it presents with the sacral incline with base on one side of the plumbline and apex on the other, which is confirmed by x-ray then the measurement is taken and if over 12mm, the heel is built up to the full amount and the sole to 9mm.[9]

We have next included some discussions from other authors, Otto Reimert[10], Hugh and Victor Logan[11] and William Coggins[12] who all happen to have come out of the state of Missouri.

People from this American state have the reputation of having "street smarts." Whereas a Californian might listen to wonderful stories about the sale of a certain harbour bridge, a Missourian has the slogan "show me". They want visual evidence. So it is no surprise that these Missourian Chiropractors have developed visual and x-ray analysis methods to assess the short leg. Here we present their findings as "food for thought" methods which are not without criticism, however.

Reinert Rationale

Otto Reinert was a professor at Missouri College in the 1960s which later merged with Logan College. We have included his thoughts and opinions, not just because his "Chiropractic Procedure and Practice" textbook is a "cult classic" nor the fact that he visited our shores in the late 70s, but because he introduced some original concepts to the literature.

On the use of Lifts, Reinert wrote[13] that: "When pelvic tilt occurs from anatomical leg deficiency, the resulting spinal curvature may be prevented, reduced or controlled by the timely insertion of a lift in one shoe, further complemented during sitting by an ischial lift (a procedure also favoured by the Logans). Even when there is not true leg deficiency, a lift may be used to compensate for structural anomaly in the spine, or to alter the relative attitude of the spinal segments (with this last statement, we can visualise the steam coming out of DeJarnette's ears and there is a vision of BJ Palmer doing cartwheels down the corridor).

A change in the level of the pelvis resulting from the placement of a lift will induce compression of the intervertebral disc on the elevated side, producing the greatest change at the lowermost movable vertebral joint. This compression of the annulus fibrosus alters the shape of the nucleus pulposus and often its relative location within the disc. This, the fulcrum of balance for the superior vertebra is varied, forced in the direction away from the site of compression.

The radiographic evidence of eccentric displacement of the nucleus pulposis is the increased intervertebral space on the side of displacement. Accordingly, if there is increased intervertebral space at the level of the lowermost movable vertebral joint on the same side as pelvic deficiency, the placement of a lift on this side will restore the nucleus toward central position and improve spinal balance. Conversely, if there is increased intervertebral space at the level of the lowermost movable vertebral joint on the side opposite pelvis deficiency, the placement of a lift under the deficient side will only serve to force the nucleus pulposis to greater eccentricity and increase the acuity of local curvature, even though the pelvic level may have been improved.

Summarising and establishing a rule:

(a) Always use a lift under the side of pelvic deficiency if there is increased intervertebral space at the level of the lowermost movable vertebral joint on the side of deficiency.

Dia. 8

(b) Tentatively use a lift under the side of pelvic deficiency if the intervertebral space at the lowermost movable vertebral joint is bilaterally equal, subsequently rechecking and removing lift if the space becomes less on the side of lift.

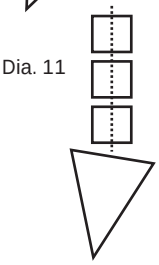
Dia. 9

(c) Never use a lift under the side of pelvic deficiency if the intervertebral space at the lowermost movable joint is less on the side of deficiency.

Dia. 10

(d) In conditions of lumbosacral anomaly, a shift of the nucleus and thickening of the annulus may compensate for the deficiency, permitting the lowermost movable vertebra to rest in level attitude. There is no need for a lift even though there is pelvic deficiency.

Dia. 11



Reinert also had some thoughts on the amount of lift to be used in the compensation of a leg deficiency. He wrote[14]: "following leg trauma which may have drastically altered leg length, total compensation for the deficiency should be made. However, no more than 7 – 9 millimetres of the deficiency should be compensated by a heel lift alone, since unilateral elevation of the heel alone will induce an anterior drift of the pelvis on that side among other complications. In severe deficiency, the entire under surface of the shoe, including the sole, should be elevated." This last, the heel and sole lift as we have previously mentioned was favoured by DeJarnette. Two points of note, DeJarnette used it only when it didn't interfere with category correction and the second point we have hinted on is the practicality of finding a boot maker to heel and sole your shoe in these times.

Another point which we will make more mention of a bit later in this article is the matter of arch support v. heel lift. As described by Reinert[15]: "In many cases, leg deficiency is actually a result of a prolapse of the longitudinal arch in one foot. The fitting with a suitable arch support rather than a heel lift is the indicated correction."

Logan Rationale

We have described how DeJarnette termed the true short leg situation as the "oblique sacrum." DeJarnette also talked about the "V" sacrolumbar curve which resulted when the lumbar curve moved back to the plumbline as in Diagram 12.

Dia. 12

'V' Sacrolumbar Curvature

The Logans (father, Hugh – son Vinton of Logan basic fame) went one step further by stating that[15] there are three points at which unilateral deficiency may occur, namely, at the point of support by the head of the femur because of traumatic or pathological leg deficiency, at the sacral articulation with the ilium because of inferior and anterior sacral subluxation and thirdly, at the fifth lumbar body which may become unilaterally thinned or wedged and thereby decrease the support offered on the side of wedging.

Their rationale produced a system of ratios and rules to apply their heel lifts and ischial lifts. We have included their method, not just to pad out our article or to give you eyestrain but to offer an insight into an aspect of chiropractic that had been given some attention years ago. Here is Vinton Logan and Fern Murray's[17] explanation followed by our comments.

"Locomotive needs of the human body provide that the two lower extremities support the body and articulate with the pelvic structure at its most lateral extremity. The distance between the femur heads at their articulations with the acetabula, is approximately nine and one-half inches in the normal, average body. The sacrum medially situated between the heads of the femurs, under like provisions measures about four and three-fourths inches across or from the centre of one articular surface to the other. Lastly, the fifth lumbar measures approximately two and three-eighth inches across. Taking these three measurements gives us a ratio of 4:2:1

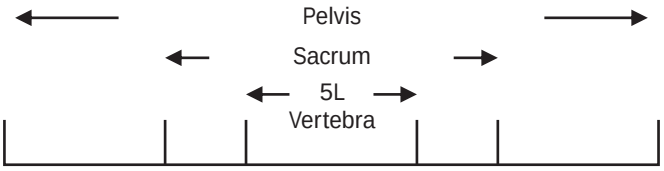


Diagram 13

While the actual measurements differ, of course, according to the anatomical structure and proportionate size of different bodies as a whole, the ratio in which they stand to one another remains alike. From the Logan ratio system it is suggested that a 1" leg deficiency on one side, causes the sacrum on the same side to be ½" deficient in relationship to the opposite side of the sacrum, and the same side of the fifth lumbar to be ¼" deficient with the opposite side of the fifth lumbar. Or, as can be seen, the relative amounts of deficiency caused are in the same ratio (4:2:1) as the relative measurements of the three structures.

The Converse (yes it is starting to look like second form geometry class) is stated as "¼" wedging of the fifth lumbar vertebra is equal in effect upon the support of the spine to ½" unilateral sacral inferiority, or to a 1" unilateral leg deficiency."

Logan When Which and How Much

One of the Logan System's rules was that a lift be placed under the side to which the body of the lowest freely movable vertebra rotates thus the side of inferior support. Remembering that the Logans suggested three points at which unilateral deficiency can occur gives us these five cases to think about.

If the defect in support arises entirely from leg deficiency, a lift must be used under the side of the leg deficiency when the patient is standing, but no lift is require when he is sitting.

If the inferior support is caused only by the two factors above the acetabula, i.e. sacral inferiority or unilateral fifth lumbar wedging or both, a lift will be needed when he is standing and when he is sitting, i.e. the ischial lift (under one cheek).

If there is a leg deficiency, sacral inferiority and unilateral wedging all on the same side, the lift will be required on the same side both standing and sitting, but in different amounts; when the patient is standing, it must compensate for all three; when he is sitting, it must compensate for only the two latter factors.

If there is a leg deficiency on one side with sacral inferiority and unilateral wedging on the opposite side, and the leg deficiency is more than enough to overshadow the other two factors, then a lift will be needed on the side of leg deficiency when the patient stands, but on the opposite side when he is sitting.

If in a similar case of leg deficiency on one side, sacral inferiority and unilateral wedging on the opposite, the leg deficiency is just enough to compensate for the other two deficiencies, then no lift will be required when the patient is standing, but an ischial lift will be needed when he is sitting, on the opposite side to the leg deficiency. (Our comment: see DeJarnette and BJ Palmer's previous actions of doing back flips and cartwheels down the corridor).

Next, the Logans had a similar conservative approach to Reinert when they stated that ¼" lift (6mm) is sufficient in the beginning; a greater amount of lift would make too radical and immediate a change in the spine.

Foot Levellers

Although there are other orthotic suppliers to the chiropractic profession here in Australasia, we have chosen to write about Foot Levellers because they tend to look at their product from a chiropractic viewpoint and are concerned with the three arches of the foot in respect to correction in terms of spinal-pelvic stabilisation. Foot levellers supply a Velcro missing region to the lower surface of their arch to which a 3, 5, 7 or 9mm lift is attached when needed. We noticed that they are in agreement with Otto Reinert's rule of not going higher than 9mm.

Conclusion:

We have examined the work of a few Authors including "the Major" to gain an understanding of the "oblique sacrum" or true anatomical short leg deficiency. Our conclusion is that much more work is needed on this subject.

DeJarnette's conclusion was (by inference, as he did give it 1970 Category status) don't ignore the true short leg as an item in your analysis but only give it its correct amount of importance. As with all of our *Expression* articles we hope you found this one of practical value and if you do have any feedback we would love to hear from you. In the next issue of "Expression" we will present the last of the 1970 Eight Category System's topic which was the Occipito-Atlantal complex.

Until then, we remain:

PETER J.KYNEUR
Toronto, Lake Macquarie
New South Wales

JOHN KYNEUR
Haberfield, Sydney
New South Wales

References:

1 – 9 DeJarnette, MB 'SOT 1970' Nebrooks
10 Reinert, OC 'Chiropractic Procedure And Practice' Marian Press, Missouri, 1976
11 Logan V & Murray F, 'Textbook of Logan Basic Methods' Missouri, 1950
12 Coggins Wm 'Basic technique' 1976
13 – 15 Reinert, OC, op cit
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LETTER TO THE EDITOR

Part 2 of a letter submitted by Dr Keith Bastian on the history of SOT in Australia

The Federal Conference in 1970 at Sydney included Dr David Desreux of Tweed Heads giving a small presentation of S.O.T.!! The first time ever in Australia, so a notable event in our history. David was an ex Canadian Air Force pilot involved in the WWII Commonwealth Air Training Scheme. After the war he studied chiropractic, I think at Palmer. Before he came to Australia he practised in Canada and became a personal friend, and an instructor for Dr de Jarnette in his early seminars, and a friend of Dr Allan Dangerfield and other early S.O.T. pioneers. His presentation was very enlightening and stimulating for me, as he talked about Dr de Jarnette's research and application to technique development. I remember especially his demonstration of what a plumbline tells you, and about standing S.O.T.O. (Step Out Turn Out) and C.O.T.I. (Cross Over Turn In). The body changes on the plumbline were immediate and inspiring. All this preceded blocks and categories.

Dr Desreux practised in Tweed Heads close to the border and also further north in Queensland. His NSW clinic had his xray machine, as it was illegal for our profession then to take xrays in Queensland, so all those Queensland patients had to do, was drive a few miles extra to have their chiropractic xrays taken. Visiting in his home, I spent hours in his office picking his brains, being adjusted and taught, and going through his collection of early S.O.T. manuals, some of the early ones being only 20 pages or so.

I remember one of around 1948 with a cream cover. One of my big regrets is that he died just a few years later. I did not find out of his death until some months later, and by then his widow had dumped all his library and returned to Canada, I believe. All that information and history sadly lost.

In those days patient clinical records were frankly "basic" if they existed at all. Case histories often had "Sick", "Back" or "HA" type notations and no examination notes and often the only visit notation was whether they had paid or not on that date. Of course, no health funds, DVA, W/C, MVA, or other paper generating, time consuming, non productive activities we have today. Not even a credit card until Bankcard came in possibly in the 1970's. "Cash or cheque Mrs Jones" was the norm, or even barter some produce, skill, or labour.

So things flowed nicely and I was seeing up to 120 patients in an 8 hour day, and only a few that I knew of, like Allan Brady and Len Welsh, were seeing more.

Len was my closest chiropractor and he was 4 hours away over the mountains, so getting an adjustment often involved taking a portable table at the weekend, driving toward each other and meeting approximately halfway. Set up the tables, adjust one another and families, have a picnic, and turn around and drive home. Conference and seminar breaks were also a busy time for checking and adjusting. There were only about 30 of us at state ACA meetings in those days.

Branch practices that many of us ran also created stress, so I wrote to the Australian Club at Palmer saying I was looking an associate, particularly one who knew S.O.T.

Scott Parker says he was sitting in the College Chapel when one of the Australians passed on my letter to him, thinking he may be interested as he was "Dr S.O.T." on campus and was close to graduating. But he and his wife were Kiwis and by now had 4 children in tow (one of whom is married to a chiropractor, and 2 who are chiropractors. Dr Scott Wustenberg is a nephew).

Scott did reply and with a very brief exchange of letters, no talk of money, tenure contacts or anything, we "shook hands" on it by mail. I arranged a lovely old home on the banks of the Clarence River with bananas, mangoes, oranges and avocados I think, (plus a few snakes) ready for their arrival just a few months after our initial contact. This was 1973. The ages of our children were not too dissimilar and we had many pleasurable social times together over the years.

In the clinic I was eager to see and learn S.O.T., and I was quickly impressed with the results Scott had with the "difficult" patients I initially had him see. Within a month or two we had switched the practice to S.O.T.!!

Category II became a big thing and produced results just as spectacular as they do today, but we did not have the indicators or tests that we have had in the last 25 years. We used mainly the plumbline analyses, arm challenge (mind language), rib head motion and UMS AND LLLL. No Basic II or Arm Fossae test. This created some hilarious times as with no A-F test, all we could rely on to check if the correction was finished was rib heads, medial knee and short leg, and with no Basic II it sometimes took literally 40+ minutes to clear those indicators. So we had patients lined up and down the street, around the corner and down the next block. They waited patiently for 2 hours plus quite often. It was interesting to see the GP's as they drove past, almost have accidents as they were gawking with their mouths open at all the patients lined up, waiting.

With Scott's instructions, I picked things up quite rapidly. Within a few months we had already created some interest with our colleagues, so we decided to run a seminar. At that year's ACA Federal Conference, Dr Fred Illi of Switzerland was the speaker, and we placed a small notice on each seat advising of our intent to teach S.O.T. The result was quite pleasing with the level of positive response. I received some flack as S.O.T. was "not chiropractic", there was "no adjustment" meaning no "cracking", and it was not "hands only." As Scott was unknown at that time, he escaped most of that.

As all this was going on, two other fairly significant things were also happening. So that we could concentrate solely on the adjusting of patients, we instituted a new type of CA. Not a receptionist/bookkeeper type, but a Clinical Assistant who worked with us and enabled us to leave routine things with her, and thus see significantly more patients in the day.

The CA would "prep" the patient, note progress, any new upsets; ensure pockets were empty, glasses off and lay them supine. She would then do BI, Condyle Rock and Stairstep (unless noted not to do so) and liver pump.

She would then leave the patient and go to either Scott or I and write down clinical notes, do cranial head holds, or finish off CMRT procedures. Then help the patient up, finalise notes, give follow up instructions for exercises or CMRT reflex advice, and reinforce the time for the next visit. She was busy! But our staff were multiskilled at front desk, 'phone, basic form filling and examination, xray set up and processing (deep tank manual), as well as in the rooms, and rotated around. They found it exciting and fulfilling.

LETTER TO THE EDITOR cont'd...

The very future of chiropractic was still very much under assault from political medicine in those days. Dr Reg Gold from the USA had a few visits to Australia and inspired us with his activism in inspiring the patients to take up the battle for their health rights. We were licensed to take xrays, but as unregistered practitioners, "health" funds did not want to know us. We had a NSW group started by ACA, I think with Dr Stanley Bolton, called C.R.O.C., Ngaire Cannon in Victoria started PATH or PACE and the other was started in NSW (CROC – stood for Chiropractic Right of Care I think, PATH – Patients Association for Tomorrow's Health and PACE – Patients Association for Chiropractic Education I think). We raised money, visited politicians, wrote letters and anything else we could, for many years. Our group in Grafton was one of the most durable and active. As well as having new patient classes in clinic, we hired a hall each week and gave Spinal Care Classes on exercise, ergonomics, etc., plus nutrition, and updates on politics, etc. Our first organisation grew out of a meeting introducing the first Dunlo pillow Sleepmaker Chiropractic mattress. We had nearly 200 present. The group were very active in the community, and once a month held a country dance to raise money for political activities and notably two other major events.

The Richards family were patients of ours for many years and we encouraged the middle son Dennis to take up chiropractic. We suggested a science degree would help his entry to Palmer College. So he went to University of New England and did his BSC with emphasis on Physiology. Our PACE group bought text books for him. When he went to Palmer we supported him also. Later his brother Anthony also became a chiropractor. Peter Cowie was another patient who has become a notable chiropractor as well. My son, Luke, some years later became a chiropractor also. About this time the chiropractic programme was starting at P.I.T. in Melbourne and the Dissection lab had a table purchased by our PACE group. Dr Kleynhans, the Head of Chiropractic had a plaque noting this placed on the table, and had a framed certificate outside his office thanking Scott and I and our PACE group for the support.

All through these years and later I was raising a family of four, was now an Alderman on the Grafton City Council and was on the executive of the NSW A.C.A., a member of Jaycees and later Rotary, as well as Chamber of Commerce, holding most offices, as well as active in church affairs. As well I had a farm and Scott and I opened 2 new branch practices at Sawtell and Casino. Later Scott's son-in-law Michael Dunn joined our practice.

Dr Keith Bastian

Membership Announcement

There will be an upcoming resolution at the AGM to increase membership from $165 including GST to $185 including GST. Please note membership fees have not increased for over 10 years (except the addition of the GST in 2000!)

SOTOA LOCUMS

LISA BARDY 0412 301 465 lisabardy@hotmail.com

STEVE DOIG (02) 9999 1680 ohe@iinet.net.au

MINDY HAYES (02) 6681 1938 mindylouhayes@gmail.com

JONATHAN LUBETZKY 0401 038 871 jlubetzky@gmail.com

JASON HENDERSON (07) 5536 4249 thenewfarmer@hotmail.com

SCOTT PALMER (02) 6672 2760 spinalscotty@yahoo.com

MARCUS SOANE 0429 625 615

BRIONY TEMPLER 0419 517 860 btempler@hotmail.com

Perth	Gold Coast
CMRT/Cranial Session August 15, 16 & 17	CMRT/Cranial Session August 29, 30 & 31
Travelodge Perth 417 Hay Street Perth Res: 1300 886 886	Gold Coast International Hotel 7 Staghorn Avenue Surfers Paradise (07) 5564 1200 Toll Free 1800 074 020

CLASSIFIED ADVERTISING

LOCUMS / ASSOCIATES AVAILABLE

New Macquarie Graduate. Available and very keen to commence work in December '08. Looking for Associate position in Sydney, or Locum work. I am hard working, friendly and have special interests in SOT and Nutrition. Contact Bryan 0422 289 948 or central_connectivity@hotmail.com

Dedicated and Proficient SOT Locum Available. Categories, CMRT, Cranial, Extremity, Paediatrics (Basic Certification Attained). Wellness Philosophy. Based in Melbourne. Available for long term / associate (Melb Metro) & short term (VIC, QLD, NSW, SA, WA, NT) locums. Associate & locum experienced in many SOT practices. Also skilled in STO, Activator, Diversified, Drop, Upper Cervical, other low force techniques, Clinical Nutrition and Healthy Living. Contact Dr Jonathan Lubetzky 0401 038 871 or jlubetzky@gmail.com

LOCUMS / ASSOCIATES WANTED

An associate is required for a thriving Brisbane practice, established 10 years ago and rapidly growing within the surrounding suburbs. Take over an existing small but growing client base from the current associate, whose change in circumstances leaves the practice with more work than it can manage. Opportunity is available to work both alongside and independently of the principal, with hours to suit you in a relaxed & flexible environment. A solid grip of SOT cranial technique would be of benefit to the suitable applicant along with knowledge in nutritional and paediatric care. Please send applications in writing to 1013 Waterworks Road, The Gap QLD 4061 or phone (07) 3300 7733 for any enquiries.

Opportunity available for an experienced SOT practitioner to join our dynamic team on the Sunshine Coast as an associate or partner if suitable. Our practice is busy with a well established client base, focusing on wellness and holistic health. Hours and days are flexible and with opportunity for expansion. Please contact Matthew by email mmoeliker@bigpond.com

Locum Required – for SOT / Low Force Practice. Excellent patients & staff in well established CBD practice. Healthy steady returns from day one. Start September / October for Spring in the South East of SA – Mt Gambier. Contact Linda on 0417 804 741 or email kirocentr@bigpond.com

PRACTICES FOR SALE

5km north Brisbane CBD. Great location. Clinic established just over 5 years ago. $120k gross clinic income last year. Income from room rented to associated therapists. They run their own business. Chiropractor works approx 3.5 days per week. Chiropractor relocating interstate. Priced to sell @ $55k Email yournewclinic@optusnet.com.au

Gold Coast Clinic for Sale – Fantastic Opportunity !! Live on the Coast and enjoy the rewards from this well located practice. Over $500,000.00 patient income pa easily achieved over each of the past 3 years. This clinic has very low overheads and much more income potential. You can run it 'as is' and own a patient income of over $10,000 per week for less than $2000.00 per month! A good old fashion clinic with a great referral and patient base. Genuine enquiries to: spinalcheck@gmail.com or Bill on 0403 005 869.

Located on Brisbane's beautiful north side, the practice is situated in a close-knit community with a large loyal client base. Established 10 years ago, the practice sees an average of 140-160 patients a week and is constantly growing with a waiting list for appointments. The main technique used is SOT and knowledge of paediatrics and nutrition would be helpful. The practice is set up to be largely paperless and all record keeping is electronic. Situated in a large house with good off-street parking and high visibility on a main road, with purchase of the premise a possibility. A longer than usual transition period can also be arranged. For further information contact Scott 0405 905 484 or email doc.scott@bigpond.com

Mt Gambier – South Australia's most liveable and affordable Regional city. Ideal CBD practice for new graduate or experienced Doctor – efficient procedures proven over 25 years with friendly, no fuss approach to chiropractic; enthusiastic CAs and fabulous patients who love to refer. Enjoy an active healthy lifestyle – all manner of recreation: land & sea; cultural centre and retail capital of the South East; world acclaimed Coonawarra wine region. One hour by air to Melbourne or Adelaide. Amazing opportunity and realistically priced – principal is needed overseas now. Why waste your valuable time commuting to & from 'everything' when it's right here at your fingertips. Time for a Life! Call Linda on 0417 804 741

Brisbane North – Currently one full day & 2 half days per week. Solid patient base. Established 14 years. Primarily SOT. Contact 0408 035 565 – use sms if no answer or chiroj@y7mail.com