

What is the FDM?

Where did it come from?

What does it mean to me?

Are you a physical therapist, a chiropractor, an osteopath using manipulation, or an orthopedic surgeon? Well, then the FDM, or fascial distortion model, could very well put you out of a job within the next decade or two. . . . That is, unless you learn it.

Are you an athlete with a sprained ankle? Now you can get that ankle "fixed" and be out competing again the same day.

Have you suffered with chronic back pain for many years, and seen doctor after doctor for every conceivable treatment -- even surgery? You may be surprised to learn ***you don't have to live in pain!***

And you can thank Dr. Stephen Typaldos.

The Man behind the Model

Stephen P. Typaldos, D.O., developed the Fascial Distortion Model (abbreviated FDM) because he was dissatisfied with the prevailing approach to musculoskeletal injuries -- prescribe pain killers, order a splint, and send them to physical therapy.

Trained in family practice and experienced in emergency medicine, Dr. Typaldos saw his share of acute injuries and chronic pain. And many of the complaints were similar, even identical. However, they did not correspond to the anatomical model he learned in school.

Could it be that something other than muscle tears, worn cartilage, and inflammation was causing the pain and loss of motion?

Yes, the fascia! Dr. Typaldos set aside his osteopathic training and went hands-on, pushing where patients told him to, trying new and more aggressive approaches. His efforts brought results, and results that could not have been possible under any other model.

Extensive research in the medical literature turned up an old book that mapped the body's fascia. And the pathways and positioning corresponded perfectly to patients' descriptions of pain, solidifying the anatomical basis for his newfound success.

His research on cadavers offered further evidence for the fledgling Model, and piqued his curiosity about the numerous functions that fascia performs in the human body.

The Model

Dr. Typaldos always emphasized the importance of the Model over the treatments. We at Triggerband, along with Dr. Typaldos's closest followers, firmly and adamantly maintain his emphasis. Many a well-meaning practitioner has inquired about the FDM, for the sake of adding a few more techniques to his repertoire. While this may impress patients with breadth of knowledge, and astound colleagues with unparalleled results, it does not do the Model justice.

This discovery is on a par with the germ theory, and like any discovery of this magnitude, it is unrealistic to expect the originator to develop the implications of the Model to their fullest extent. A case in point: the Wright brothers opened up a world of new possibilities with their historic flight on December 17, 1903 at Kitty Hawk, North Carolina, but it would be absurd to model current aircraft on the blueprint of the Wright Flyer.

Having said that, Dr. Typaldos developed manual and device-assisted techniques that, in his own words, are "better than anything else out there." Furthermore, the Model explains with precision why current treatments work or fail,

and when they will work and fail. For example, at our most recent international meeting, a highly-skilled FDM physician explained how he only sends patients with tectonic fixations to the orthopedist for joint injections. The rate of success is virtually 100 percent; whereas, joint injections on other patients are basically hit-or-miss.

So we implore those practitioners who are considering or already using Typaldos Manual Therapy to “think within the Model.” We do realize, however, that for the established practitioner, this is easier said than done. . . .

Indoctrination

It may come as a surprise to those outside the healthcare field to learn that training in a method and underlying philosophy of healing is akin to religious indoctrination, and also military training. It profoundly affects the inductee’s entire world view, invites him into one of society’s numerous subcultures, and subtly but forcefully demands that he remain within the prescribed model or be guilty of heresy.

Even those practitioners who are consciously and actively setting aside their prior training, so they may “think within the Model,” can sometimes struggle to do so for years without complete success.

Because of the depth of impact this early training has on practitioners’ entire careers, we are interested in teaching the FDM to DO, DC, and PT students as early in their studies as possible. A long-term goal is to open an educational institution offering a master’s or doctorate degree in TMT.

Research

Dr. Typaldos based his findings on clinical evidence accumulating over more than a decade, while he was treating upwards of 25 patients a day – a heroic feat if you ask those who learned under him, because many treatments are quite physical! Nevertheless, Dr. Typaldos had not, as of his untimely death two years ago, published a detailed study of either case histories, or anatomical or cellular analysis of the fascial system.

Also, Dr. Typaldos long desired to see the FDM make its impact in the realm of surgery. He theorized that cylinder distortions around the coronary arteries could cause acute myocardial infarction, and that cylinder fascia around the arteries to the brain might cause stroke.

We are dedicated to pursuing these research goals as a means of advancing the knowledge and practice of FDM; but not, as others have suggested, of “proving” its efficacy and validity. . . .

The FDM and the Healthcare System

In the fall of 1991, when Dr. Typaldos discovered the first fascial distortion types, he expected his more senior colleagues in medicine to take the discovery and run with it. That expectation proved to be very mistaken. Instead, Dr. Typaldos discovered more distortions in the profession than in the human body, and they impede the breadth and speed at which advances move through the healthcare system.

We hold that a profession that either resists or dismisses effective treatments and their theoretical basis, for reasons other than the good of patients, is in need of a major overhaul. We have watched in amazement for the past 16 years the bizarre, irrational, and unreasonable responses doctors have given to undeniable evidence of the truth of the FDM.

One example was a doctor in the emergency room who witnessed Dr. Typaldos fix a sprained ankle. He watched the patient limp in on crutches wearing a splint. He saw the patient stride perfectly without assistance following treatment. His question: “Is that a new style of splint she was wearing?” The mind can become so narrow that it misses the obvious.

A second example is from one of Dr. Typaldos’s lectures, where he treated and fixed another sprained ankle before a live audience. One of the doctors in the audience raised his hand to interrupt, “I want you to know that I would still put a cast on that ankle.” Why, when it’s as good now as if there had never been an injury? Because this doctor’s model says that sprained ankles take weeks to heal. Even witnessing an instantaneous healing with his own eyes was not enough to alter his thinking.

Then what can we do to enact change in the profession? We have our plans, but we may also have help forthcoming. . . .

The *Healthcare Crisis*

Signs indicate that the medical profession is approaching a crisis; and the healthcare system is about to undergo phenomenal changes. Here are facts that lead us to believe change is in the air:

1. The extent and growth of alternative medicine. Many physicians mock and deride what they see as ludicrous alternatives to standard medical practice. But they ought to realize that the more ridiculous these other forms of healing are, the more dissatisfied patients must be with standard care for them to seriously consider such alternatives. Furthermore, numerous MDs and DOs are now practicing certain types of alternative medicine.

2. Talk of “socialized” healthcare. In this presidential election, for the first time, socialized medicine is a topic of serious consideration. An ambiguous term, loaded in connotations, “socialized” conjures up images of the old USSR. In fact, there is a whole spectrum of government interventions that could get labeled “socialized medicine.” It is naive to think increased government regulation will solve healthcare’s problems, but the fact that many Americans are eager to make extensive changes shows that they are not happy with the current system.

3. Decision-making is being taken from doctors. HMOs, insurance companies, and the legal system all exert a strong influence over doctors and how they treat patients. Insurance tells them what is medically necessary; malpractice lawyers are ready to punish doctors who take chances; and high patient volume means doctors have to get patients out the door quickly, without taking the time to really think about each case. Perhaps the most alarming manifestation of this trend is that pharmaceutical companies unashamedly advertise prescription medication to patients, and tell them to ask their doctor to prescribe it. And doctors do it.

4. Use of physician’s assistants (PAs) on the rise. Especially in the area of family practice, and also in emergency medicine, PAs are taking over. This meets an immediate need where there are physician shortages. However, PAs are doing the job well, and could replace physicians in the long-term. Family practice has become a very mechanical process, so this development is not surprising.

5. Physical therapists are doctors too. Awarding physical therapists the doctorate degree, as most PT schools are now doing, is sending a clear message that they want to be the top professionals in the area of sports injuries and chronic rehabilitation. Chiropractors already have a large part of this niche, but they are outside the healthcare system. Insurance and employers like this, as PTs cost less than MDs or DOs. And if no one is effective at treating injuries, you might as well have a PT doing it instead of a doctor . . . or is a PT a doctor?

This last point highlights why we are targeting PTs and DCs as prospects to train. MDs and DOs just don’t have a lot of say in the field of manual therapy any longer. Even more, because of the way the healthcare system has compartmentalized physicians, their advocacy can do little to advance the support of FDM within the system. . . .

Why a doctor’s success can be his failure

Top-of-the-class, ambitious, competitive, and highly intelligent, your average medical doctor knows little of failure. A few “C” grades (or “B” grades in certain classes) in college, and medical school is out of the question. Doctors undergo a demanding medical school course that gives them little time to ponder whether the material they are learning makes sense. They work hard to try to get the best residencies; and when they have them, they begin an insane workload that wears them down with stress.

In their efforts to excel, most doctors lose the most important ability of all – the ability to handle failure. Their reputations, their sense of self-worth and purpose are all wrapped up in their professional success. So, when they work in areas of medicine that are largely ineffective, they devise ways to make it appear that they are helping patients when, in fact, they have no idea how to help. Thus, they deceive themselves into believing failures are successes. These hollow forms of treatment are worse than pitiful – they are dangerously limiting. The doctor who thinks he has an effective way to treat an illness will not search for something better. Nor will he welcome a better approach if told him; for it is not easy for him to admit that all prior methods were bogus, and results were total failures.

The physician often places his own ego above the needs of patients. . . .

Three principles of success: The Foundation upon which the FDM is based

1. Listen to patients – patients inherently know what is wrong with them.

When was the last time you listened to a patient for 30 seconds without interrupting?

2. Be honest with yourself and your patients – only models and methods based on the truth will stand the test of time.

If your approach doesn't work, reassess. If the patient is no better, don't tell them they are.

3. Assume your patients' burdens – when patients come into your office, their burdens become your burdens. Give them the attention they need.

This principle is, perhaps, the most important of the three, because doctors who practice this principle will naturally practice the others. Your patients are a burden in your office for a few minutes to a few hours at most. However, their illness or injury is a burden to themselves and their families for days, weeks, months, oftentimes years. Is it worthwhile to set aside ego and comfort, and learn what is ailing patients so you can help them?

It was not genius that enabled Dr. Typaldos to see such remarkable success. It was his willingness to admit his shortcomings, and to search untiringly until he found solutions that adequately addressed his patients' complaints.

This essay originally appeared on the website *typaldos.org*.

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March, 2008