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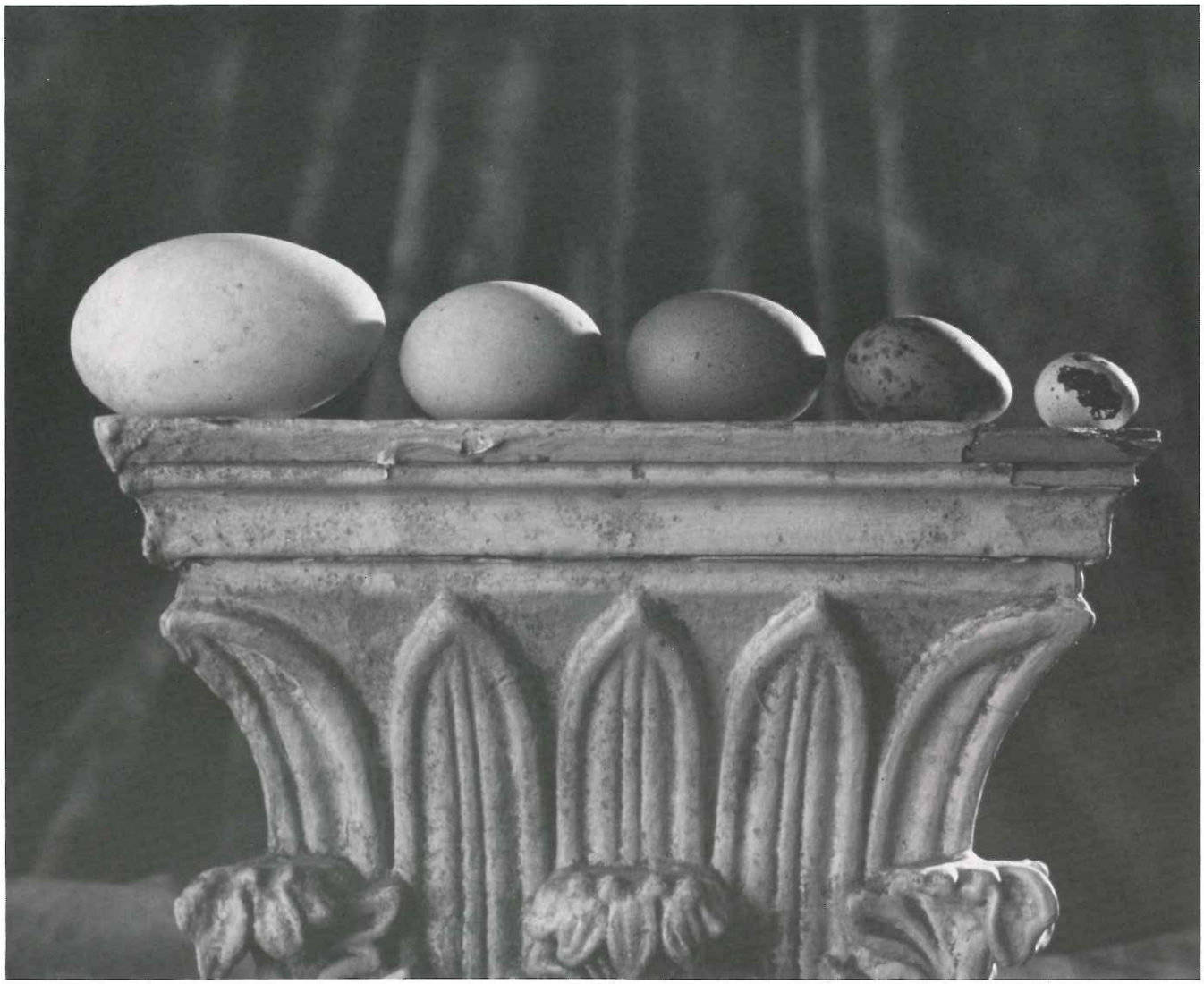

WHO WILL HATCH OUR STUDENTS?

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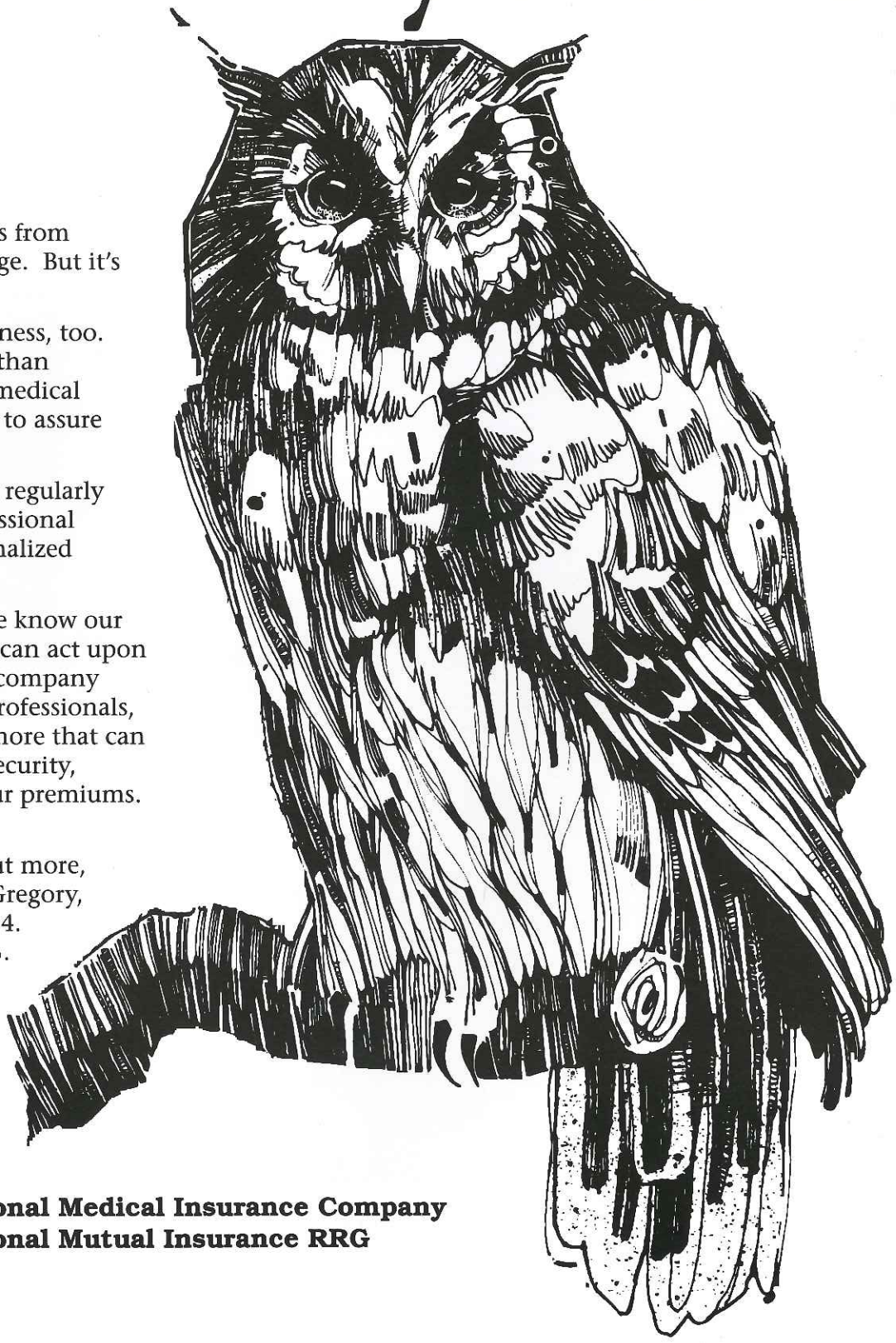

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JOURNAL

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From The Editor: The Best Things in Life

by Raymond J. Hruby, D.O., F.A.A.O.

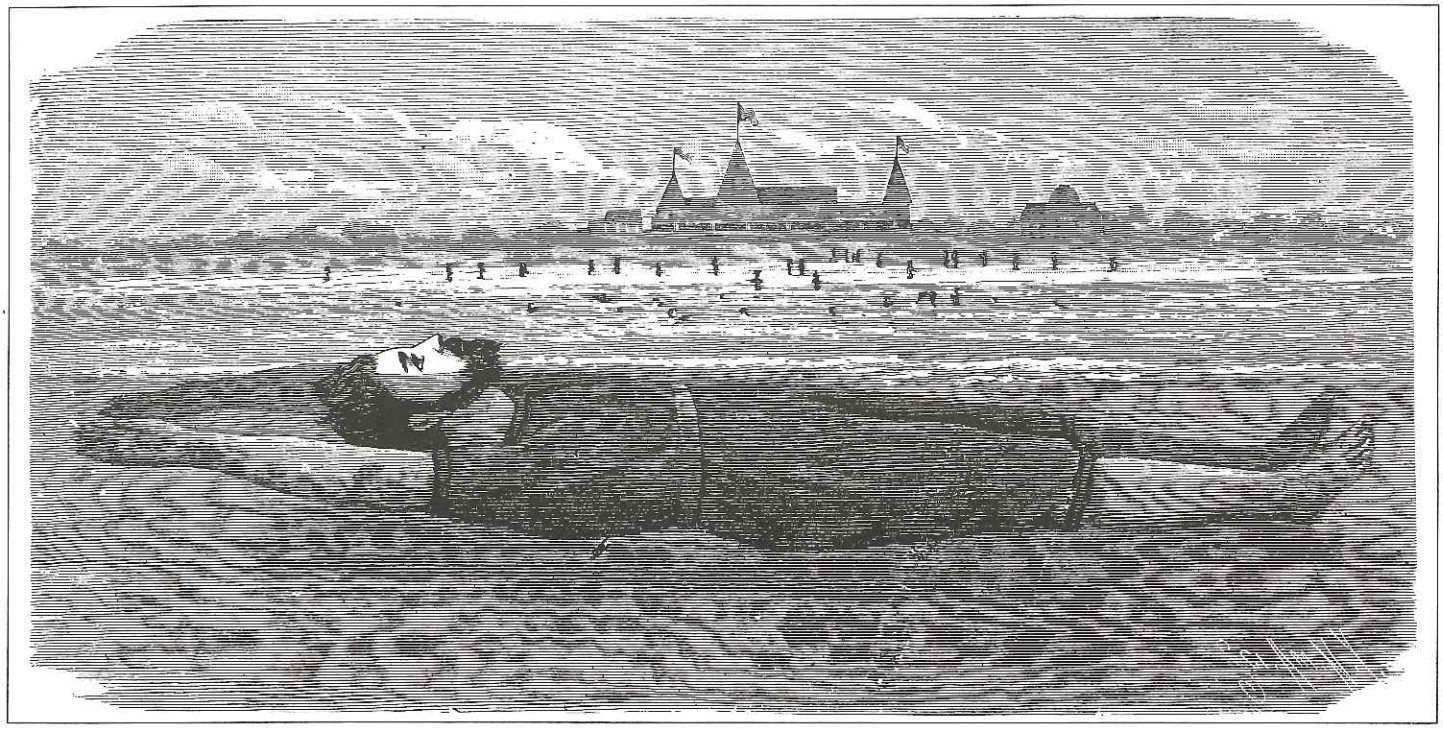
These days it is difficult to get away from the business aspects of running a practice. What with increasing amounts of paperwork, government intervention, malpractice costs and other similar items, many physicians wonder whatever happened to just plain old taking care of patients. One wonders if it will ever end, or at least get a little easier. Henry David Thoreau, one of my favorite writers, had a lot to say about how we should simplify our lives and not get so overly involved with business affairs that we lost sight of the true joys of life. In his work, Life Without Principle (page 2), he said: "It would be glorious to see mankind at leisure for once. It was nothing but work, work, work."

Osteopathy is our livelihood, so we can't ignore the business of running a practice. But somewhere in our lives there has to be a balance between business and pleasure, and I submit that it is against osteopathic principles for us not to seek this balance.

We worry about success, and we worry about achievement. But what is success, and what exactly are we trying to achieve? Obviously, the answer is different for each person, but for me I find it helpful on a regular basis to do two things. First, I like to list my gaols in life, and reassess them every so often. When I do this, I find that success for me doesn't mean a flashy car or a sailboat. Rather, success means having a pleasant home, a reasonable income and the ability to do the second thing: count my blessings.

When I think of all the joyful things I have available to me — my wife, my friends, the New England countryside, the ocean, the Academy — then I realize that I'm already successful, and that the things that really count in life are right here in my back yard, not in some fancy car lot, or on some cruise ship. Ralph Waldo Emerson had one of the best definitions of success I've ever read: "To laugh often and much; to win the respect of intelligent people and the affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty, to find the best in others; to leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; to know even one life has breathed easier because you have lived. This is to have succeeded."

So when you're feeling overburdened with the "business" of medicine, perhaps some of these words will help. Perhaps you'll be able to relax a little in your practice, enjoy your patients a little more, and take a fresh look at life again. In the same book noted above (page 20), Thoreau said: "It requires more than a day's devotion to know and to possess the wealth af a day." Think about it. It makes a difference. ▲



In Fond Memory Of Richard Darby, D.O.

Dr. Richard Darby lost his fight with cancer and passed away on July 3, 1991. He is survived by his wife Maria Elena, son Bruce Darby, daughter Marni Lax, and one grandchild.

Dr. Darby was born in New York on August 18, 1934. He graduated from the Brooklyn College of Pharmacy, Long Island University in June 1956 with a B.S. in pharmacy with honors and Philadelphia College of Osteopathic Medicine in June 1963 with honors. He completed his internship at Grandview Hospital, Dayton, Ohio. He held current licenses to practice in Arizona, California, Missouri, New Jersey, New York, Ohio, and Pennsylvania. He was certified by the American College of General Practitioners.

Dr. Darby most recently practiced in Scottsdale, Arizona from 1963 to 1964 and in Phoenix, Arizona from 1964 through the time that he retired from general practice in 1989.

Dr. Darby was a member of the American Osteopathic Association (Committee of Medical Economics); American Academy of Osteopathy (President 1989-90, Board of Trustees, Chairman of the Adhoc Committee on Terminology, Chairman

Richard Darby, D.O.

of Muscle Energy Task Force); Arizona Osteopathic Medical Association (Past President-District Two, Past President 1985-1986, Chairman of the Insurance Review and Professional Relation and Grievance Committee, Member of House of Delegates); Arizona Academy of Osteopathy (Secretary-Treasurer); Maricopa County Osteopathic Association (Member of Board of Trustees, Vice President, President); Arizona Medical Association (Legislative Committee); Maricopa Foundation for Medical Care (Review Physician, Member Board of Review Physician - Past); Medicare (Osteopathic Consultant); College of Osteopathic Medicine in the Pacific (Adjunct Clinical Faculty, Preceptor; Kirkeville College of Osteopathic Medicine (Preceptor); Philadelphia College of Osteopathic Medicine (Preceptor, Alumni Board of Trustees, Preceptor, Regional Chairman, Alumni Fund Campaign; Michigan State University (Assistant Clinical Professor, Preceptor; and Arizona Board of Osteopathic Examiners (Vice President).

Dr. Darby was a certified instructor in Osteopathic Manipulative, Counterstrain, Muscle Energy, Myofascial and Cranial Techniques. He held staff position with Phoenix General Hospital and Community Hospital Medical Center. He lectured and conducted workshops for national colleges. Dr. Darby was named General Practitioner of the Year by the Arizona Chapter of the American College of General Practitioners in 1986.

Dr. Richard Darby was loved and respected by all who knew him. He was a leader in the osteopathic profession and a leader in life as a special individual and friend. He was an inspiration, compassionate, witty and wise. Dr. Darby has left a large void for many and will be missed by all. ▲

Carl Moore Cook, D.O., Memorial Fund Established

Rosemary Cook (Mrs. Carl), has notified the Academy that it is to be a beneficiary of her estate. The amount will be sufficient to establish a permanent principal fund named the Carl Moore Cook, D.O. Memorial Fund. Income from this fund will be used for the purpose of perpetuating and improving upon the study and the therapeutic use of osteopathic manipulative therapy. To open the fund Mrs. Cook has recently transferred a sum of money from an Arizona bank to the Academy. This amount has been invested for income in a separate fund titled the Carl Moore Cook, D.O., Memorial Fund.

Carl Moore Cook, D.O., was an Honorary Life Member of the Academy and for over forty years worked ceaselessly to pioneer and further Osteopathy in England. When in 1967 his health broke completely obliging him to retire and return to the U.S. to live in the warm dry climate of Arizona, his greatest regret was that he could no longer continue the work to which his life was dedicated. It was his wish, and his wife Rosemary's also, that such money as there might be left after Rosemary's death should be used for the teaching and providing of manipulative osteopathic therapy. ▲

WHO WILL HATCH OUR STUDENTS?

by LLoyd Morey, D.O.

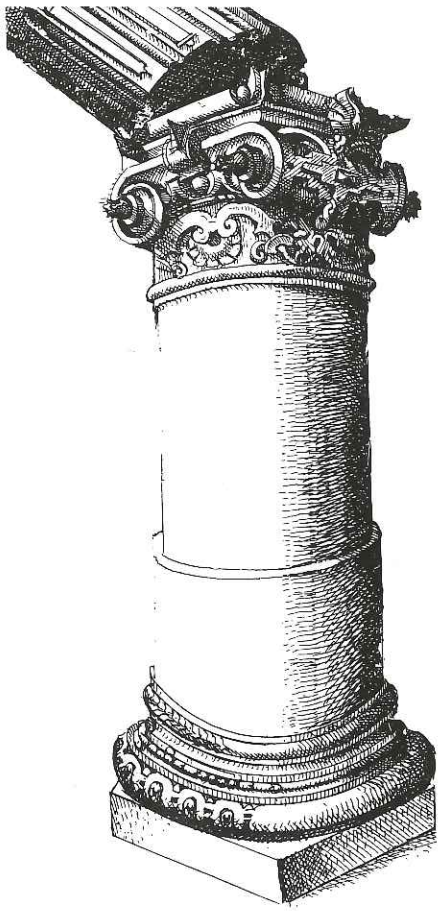
Our Osteopathic students are at a crossroads of crisis. Who will hatch and ultimately raise them? They need certification in something to garner hospital privileges so that they can offer "better" health care to their patients or achieve some other future financial advantage. Not all Osteopathic postdoctoral training programs are what our students perceive as approaching the degree of adequacy offered by a wide variety of now available allopathic programs, not to mention the "prestige" of attending a fine allopathic institution.

Do we have a realistic alternative to offer our really fine Osteopathically oriented students? We certainly do! The utilization of Osteopathic manipulative skills in the average D.O./G.P. office varies a great deal — from nil to a majority percentage. In our Osteopathic hospitals, the use of OMT seems to be far less — even among those D.O.s who use it more frequently at the office level. In general, those D.O.s who practice the majority of their practice in manipulation "only" appear to be a very small number in our profession — limited to most of them being independent freestanding D.O.s and many of the rest in Osteopathic colleges and a few Osteopathic hospitals.

Possibly, by examining the causes of the problem, we can create some solutions — the object being to create an interest in Osteopathic students in the effective and frequent utilization of manipulation, and in our graduates continuing this practice in at least a majority of their patients — to create a trend away from us all becoming allopathic D.O.s — as is now the case!

The pre-graduate clinical training years begin to trend away from the belief and training of the basic science teachings. We need to encourage our students in every way possible. Any Fellowship Program resulting in an extra year of pregraduate training should result in a year of residency training credit in that field. So also for approved preceptor trainees in one year programs.

Students actually complain of instructors who will not or don't know how to do the Osteopathic principles and practice in the classes they teach. With the students help — possibly through post-course surveys without identifying student names — those minority (hopefully!) numbered instructors can be identified and replaced as soon as practical. The same needs to be done in the postgraduate training years, because the number of unqualified instructors rapidly increases at that time.



Many of our clinical instructors have not been given Osteopathic manipulative instruction in their specialties since graduation. How can they teach that which they do not know? We are taught to use the best type of technique for the patient — yet many do not know or even suspect that there are new techniques developed over the last five or ten or twenty years, and that during the same time, these and the older techniques have been improved upon, and their application to special visceral problems well proven and enhanced.

So, we need a pool of instructors — as approved by their peers — to teach malleable present instructors the scientific basis and practical use of Osteopathic techniques. Where do we find these D.O.s who have proven expertise in understanding Osteopathic principles and their appropriate practice of manipulative techniques?

Surprisingly — to many — they already exist — through a program created by the American Academy of Osteopathy many years ago. Through careful scrutiny and tough examinations, a small number of D.O.s achieved the status of Fellow in the AAO — tantamount to certification in Osteopathic manipulative medicine now - but only after much unfortunate politicking — the AOA has created an independent "Board of Special Proficiency in Osteopathic Manipulative Medicine" — an acceptable route for certification in advanced understanding in the practice of the principles of our heritage.

Much also has been said that graduated D.O.s should already be doing "this" in their practices — but everyone knows that "they" cannot present a realistic argument in this area. We need special people with special understanding in a wide range of the use of multiple special techniques — just as in any other specialty. As a member of that Board, I can assure you that this lofty goal is being accomplished through rigorous standards and testing. Not everyone who applies can pass. They

may flunk themselves by failing to pass written, oral or the practical parts of the various examinations. Those who pass demonstrate a very high calibre of training and understanding.

Is there any interest in this process? You betcha! Undergraduate affiliates of the AAO flourish in many of our colleges — students dedicated to analyzing, practicing and perpetuating osteopathy — the wave of the future! By the same token — we must provide them with qualified instructors, pathways to certification, and jobs when they have accomplished that which has been mandated.

We must consider restructuring specific areas of our training institutions. OP&P Committees in our various hospitals should become full fledged departments, chaired by a certified individual from the process herein-before described. Full-time individual hospital D.O. practitioners, based on the model of Stiles and McDonald[1], need to be available for consultation, specialized manipulation, and to prove to third party payors that osteopathic treatments can result in shorter hospital stays in all aspects of hospital therapy. They can also help train our D.O. pre- and post-graduate students and any other interested D.O.s in general, as well as to provide specific instruction in various manipulative techniques for all clinical specialty areas. This is not "a pie in the sky" idea — it is essential to our survival as a profession. Besides, this concept is already being practiced in some of our hospitals and colleges.

To assist in superior Osteopathic care a treating room with at least two cubicles should be located adjacent to each nurses' station in each Osteopathic hospital. With chronic in-hospital patient shortages facing most hospitals — this slight structural modification should not present any burden. Besides, hospitals have neat ways of charging for any space used for any patient. Of course, outpatient facilities for OMT need to be provided — at no threat to staff members.

We need to provide statistical analysis of Osteopathic manipulative treatment benefits as described in the recent JAOA article by Richard W. Koss, D.O.[2] A simple, one page checklist can be used. Without this, our profession could simply just be eliminated or suffer the results of a very poor fee schedule by many third party payors.

Independent D.O.s or those associated with various Clinics can make a great living — at least as good as their harried G.P. colleagues — with a "manipulation only" type of practice. Fewer hours, less stress, markedly decreased overhead, and a superior family life await the D.O. who practices his Osteopathic ideals.

We can work miracles with our hands! We need to be given the appropriate training and peer review so that we can prove it to all of the skeptics! ▲

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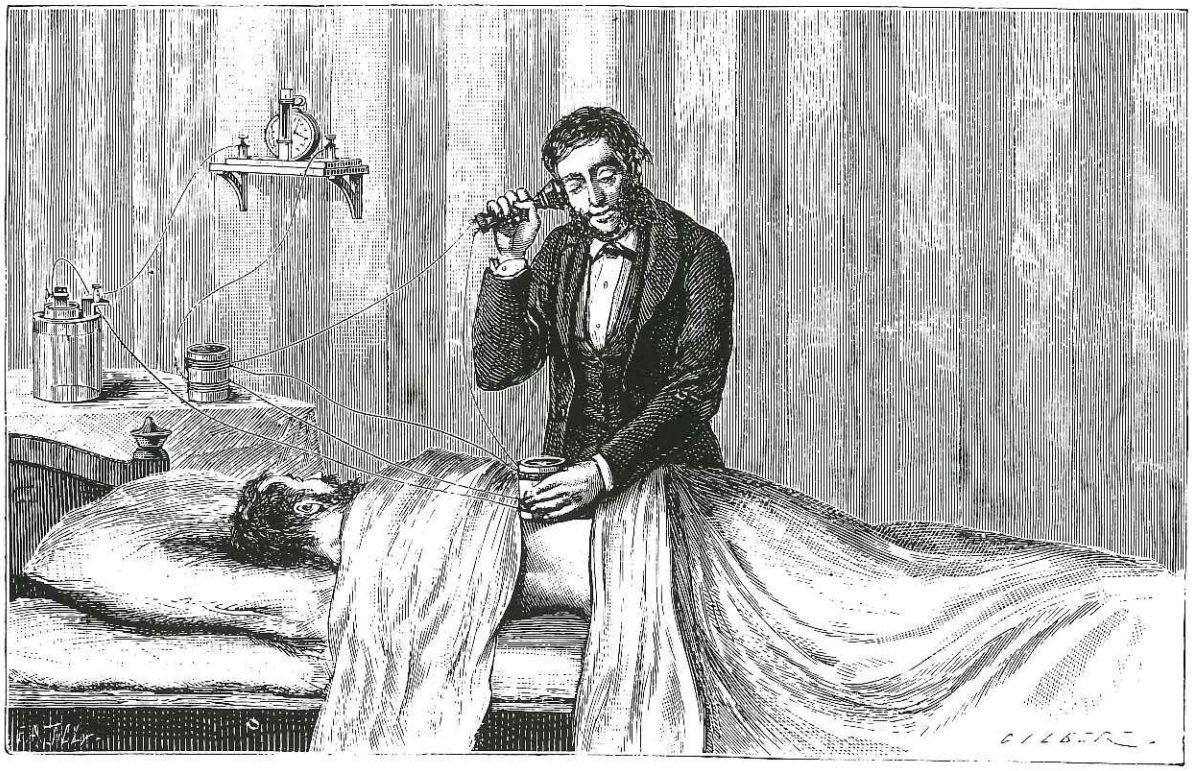
1. Stiles, Edward G. *Osteopathic Manipulation in a Hospital Environment* JADA 76: 243-58
2. Koss, Richard N. *Quality Assurance Monitoring of Osteopathic Manipulative Treatment* JADA 90:427-34



Pathophsysiologic Models: Aids to the Selection of Manipulative Techniques

by Raymond J. Hruby, D.O., F.A.A.O.

Models of the Disease Process

Osteopathic philosophy holds that the musculoskeletal system is intimately involved with any pathophysiologic process that occurs in the body. The musculoskeletal system interacts with its environment by maintaining proper communication with other body systems, such as neurologic, endocrine and immune systems. These other systems support the musculoskeletal system by such activities as providing oxygen and nutrients, removing metabolic waste products, and facilitating reparative and defensive functions. When communication between the musculoskeletal system and these other body systems breaks down, then dysfunctions and disease states can occur. The disease state may be associated with any or all of the following phenomena:

1. Excessive demand placed on visceral structures by the musculoskeletal system.
2. Abnormal stimulation of the nervous system by the musculoskeletal system.
3. Excessive or inadequate response of the visceral system to the demands of the musculoskeletal system.

It follows logically that the musculoskeletal system must be considered in the formulation of a method of understanding the presenting pathology. In the course of evaluating the patient, the osteopathic physician will not only determine what the presenting disease process is, but will also demonstrate the presence of associated somatic dysfunction. Based on the history, physical examination and structural evaluation, the osteopathic physician will select an appropriate treatment for the patient's condition. Additionally, a pathophysiologic model can be chosen for the manipulative management of the disease process, which allows for the selection of appropriate manipulative techniques for the given condition. Greenman has shown that such a modeling process, along with knowledge of the principles of various types of manipulative techniques, can help to make manipulative treatment of the somatic component of various illnesses much more effective. Additionally, the Educational Council of Osteopathic Principles is proposing the use of such models as part of a core curriculum to be used in all osteopathic medical schools. Some common patho-physiologic models used are: biomechanical, respiratory-circulatory, behavioral and bioenergy.

Biomechanical

The biomechanical (or postural-structural) model may be the most common one used in osteopathic structural diagnosis and treatment. This model looks at the human body from the standpoint of the musculoskeletal system, and views the body as a connected grouping of bones, muscles, ligaments and fascia. Various types of stresses on the body are seen to manifest themselves within the musculoskeletal system as alterations of posture, motion and gait. These stresses are thought to act in the following ways:

a) Compensatory mechanism in the biomechanical system may stress segmental levels of the spinal cord, causing spinal cord reflex disturbances and subsequent dysfunctions in related somatic and visceral structures.

b) Stresses on connective tissues can result in altered metabolism in the extracellular fluid environment, thus initiating and mediating somatic and visceral dysfunctions.

c) The combination of connective tissue stresses and muscle imbalances eventually leads to decreased joint stability, and thus affects joint range of motion. Additionally, these changes lead to altered postural mechanics, along with increased energy expenditure and possibly the eventual development of degenerative joint changes.

d) As the above stressors persist over time, associated weakness in ligaments and connective tissues may result in irreversible changes in joint structure and postural mechanics.

Therapeutically, this model is used in applying manipulative techniques which allow for restoration of balanced posture and efficient use of musculoskeletal components. This model is useful with sports injuries, and with somatic dysfunctions resulting from trauma.

Neurological

The neurological model is probably the most widely understood model known to osteopathic medicine. The phenomena of segmental facilitation, proprioceptive functions, and axonal transport (see "Pathophysiologic Principles", above) contribute to the formation of this model for clinical use. In this model, the physician considers the level of function of the patient's nervous system, paying attention to both the central and peripheral portions of this system. Specifically, one considers both the somatic nervous system (SNS) and the autonomic nervous system (ANS). Each of these subsystems can be effected by manipulative treatment.

Pathological influences such as trauma, poor posture or visceral dysfunction are transmitted via afferent nerves to the spinal cord. These altered stimuli are processed at one or more segmental levels within the spinal cord, or are transmitted along spinal cord pathways directly to the brain for resolution at that level. Manipulative techniques directed at restoring normal muscle function and increasing joint mobility can reduce the amount of altered afferent input that must be processed by the brain and spinal cord.

Efferent impulses are carried to the skeletal musculature by somatic efferent fibers, and to the viscera by efferent pathways in the sympathetic division of the SNS. Of particular interest to the osteopathic physician is the effect of the ANS efferents to the skin. Changes in sudomotor and pilomotor activity, as well as changes in vasomotor activity in the arterioles of the skin, result in some of the tissue texture changes that are found on palpation, and which help the osteopathic physician to determine the presence of somatic dysfunction. Because of the arrangement of the ANS which provides an anatomical and functional connection between the skin and the internal organs, these palpatory findings may be indicative of altered function of the segmentally related internal viscera.

Alterations in musculoskeletal or visceral structures that result in increased mechanical stress on these tissues also result in increased pain perception. All of these factors contribute to the development and maintenance of somatic dysfunction relative to the specific body areas involved. Manipulative treatment using this model includes techniques that reduce mechanical stresses on tissues, as well as techniques that reduce nociception. Additionally, manipulation may also function to stimulate the body's production of endogenous opioids for the reduction of pain and resolution of somatic dysfunction.

Respiratory-Circulatory

A. T. Still believed that the human body required proper and efficient arterial, venous and lymphatic flow in order to function in a healthy state. In his own words: "The rule of the artery must be absolute, universal and supreme, or else disease will result." When using the respiratory-circulatory model, the osteopathic physician considers the patient from the standpoint of the circulation of blood and lymph throughout the body, and the potential for the development of illness should dysfunctions of the musculoskeletal system interfere with this circulation.

To understand this model it is helpful to consider the extracellular fluid environment in which all cells of the body exist. It is within this environment that the processes vital for normal cellular function occur. The arterial system brings nutrients and oxygen into the extracellular fluid system, at which point these substances may be taken up by the cells to be used for normal cellular functions. As the cell receives these products and performs its normal metabolic functions, the waste products of these processes are returned to the extracellular fluid environment. These substances can be toxic and therefore detrimental to cell function if retained in this environment. Thus, they must be removed.

This process of removal depends upon the proper amount of venous and lymphatic return into the central circulator system, and the delivery of these waste products to the various excretory organs, such as the kidneys, skin and lungs. The movement of venous blood and lymph is largely accomplished by pressure exerted on venous and lymphatic vessels as muscles contract during normal muscular function. Thus adequate venous and lymphatic return depend on adequate muscular function.

When viewing the patient from the respiratory-circulatory perspective, the osteopathic physician takes into consideration any processes that may alter respiratory mechanics and/or muscular function, and thus impede normal blood and lymph circulation. Some of these factors include:

a) Respiratory illness
b) Scoliosis
c) Kyphosis
d) Thoracic or abdominal surgical procedures
e) Poor posture
g) Gravitational stresses
h) Mechanically induced stresses of pregnancy
i) Somatic dysfunction involving the abdominal diaphragm or the thoracic inlet
j) Obesity
k) Smoking

Osteopathic manipulative treatment using the respiratory-circulatory model focuses on maximizing the circulation of blood and lymph. Treatment may be directed at improv-

ing thoracic spine and rib cage motion, movement of the abdominal diaphragm, and movement of blood and lymph through the thoracic inlet. Additionally, treatment may also be directed at improving muscular function in the extremities, so that adequate circulation may be maintained in these areas as well. It should be remembered that arterial blood vessel tone (and therefore arterial blood flow) is dependent on normal sympathetic nervous system (SNS) functioning. Thus manipulative methods that normalize arterial blood flow by way of affecting SNS dynamics may be considered appropriate to the respiratory-circulatory mode.

Behavioral-Psychosocial

This model relates to a variety of patient presentations which are considered to be reactions to environmental and psychological stresses. It also takes into consideration the interaction between behavior and this disease process. The behavioral aspect of a patient's attempt to adapt to stressors may either contribute to a return to health or may facilitate the disease process. The model also takes into consideration the fact that functional performance is determined not only by the pathophysiology involved but also by attitudinal factors.

A spectrum of biological, psychological and sociological factors are included in the behavioral-phychosocial model. These factors may be grouped as followings:

a) Biological factors
1) Circadian rhythms
2) Genetic traits
3) Geographical and physical environment
4) Exercise habits
5) Nutrition
6) Hygiene
7) Disability

b) Psychological factors
1) Belief systems
2) Coping mechanisms
3) Personal view of health
4) Emotional stability
5) Educational background

c) Sociological factors
1) Resources available through family and community
2) Cultural background
3) Government policies
4) Gender
5) Economic and social status

The response of the musculoskeletal system to stressful factors may manifest itself in any number of symptoms. Osteopathic manipulative treatment is useful in reducing or eliminating the effects of somatic dysfunction under these conditions. This in turn may benefit the overall treatment of the patient by reducing symptoms and allowing the patient to better cope with their environmental stresses. Manipulative methods that reduce symptoms by reducing the SNS hyperactivity associated with stressful states are useful in this model.

Bioenergy

The human body constantly attempts to maintain a balance between its own energy system and that of the external environment. The bioenergy model provides a means for analyzing this energy balance and for assisting the body to accomplish an optimum energy balance. This model may be understood in several ways.

One way is from the standpoint of the body's ability to adapt to stressors, such as trauma, infection, somatic dysfunction, nutritional deficiencies, and others. It is evident that maintenance of anatomically correct relationships allows for the most efficient use of the musculoskeletal system, and lessens the energy demand on the viscera. In essence, more efficient operation of the body results in less energy being wasted. This energy conservation allows the body to better adapt to stressors. These stressors place extra energy demands on the body. An individual's ability to adapt to these stressors is directly related to his/her ability to compensate for these excessive energy demands. Additionally, several stressors simultaneously exerting their influence may act in a synergistic fashion to diminish the body's ability to maintain a homeostatic energy balance.

Changes within the musculoskeletal system itself may affect the body's ability to interact with it's external environment. For example restrictions in joint motion or soft tissues may lead to reduced efficiency of motion in the body, diminishing its energy reserves and impairing its ability to adapt to stressors.

Likewise, certain changes in visceral function may reduce the body's adaptive capabilities. As an example, poor posture may place excessive energy demands not only on the musculoskeletal system, but also on the cardiorespiratory system, thus reducing the body's energy reserves and adversely affecting its homeostatic coping mechanisms.

Osteopathic manipulative methods useful in this model depend on the specific stressor involved. Techniques directed at joints, muscles, fascia for fluid system may be needed to reduce or eliminate adverse energy demands. At times, multiple technique methods may be needed, especially if multiple stressors are involved or if multiple systems are affected by a single stressor.

The bioenergy model may also be considered in light of the body's own inherent energy. This inherent force has often been equated with the craniosacral rhythm.

Craniosacral manipulation to remove restrictions to this inherent energy can have profound effects on the body's functions. Thus, the use of craniosacral manipulative methods restore and enhance the body's inherent energy forces is another way of using the bioenergy model to evaluate and treat patients.

Summary

The osteopathic physician possesses the unique ability to integrate structural diagnosis and manipulative treatment into the overall medical management of the patient. Manipulative approaches may be classified into certain pathophysiologic models. Awareness of these models will allow the osteopathic physician to select manipulative techniques that are most appropriate for the patient's condition, and will permit a more effective and comprehensive treatment plan for overall patient management. ▲

Footnotes

1. Greenman, PE: Models and mechanisms of osteopathic manipulative medicine. Osteopathic Medical News, vol. IV, no 5, May, 1987, pp. 1-20

2. Ward, RC, Sprafkam S: Educational council on osteopathic principles project on osteopathic principles education. November, 19867, pp. 21-29

Cystic Fibrosis and a Victory for Osteopathic Methods: A Case History

by Harlan L. Wright, D.O.

On July 13, 1990 a very worried and desperate mother from a neighboring town about 100 miles away, brought her twelve year old daughter to my office and gave the following history:

Mary (this is not her real name) was born with meconium ileus and the doctors suspected she might have cystic fibrosis at that time. At six months of age the sweat test proved positive and diagnostic tests proved the diagnosis of cystic fibrosis to be correct. Then began a long history of increasing pulmonary congestion, asthma, repeated upper respiratory infections, coughing of gradually increasing severity, frequent and repeated trips to many different doctors until she came under the care of a cystic fibrosis specialist (an M.D.) for the past several years.

Every six months Mary was put in the hospital for two weeks for extensive laboratory testing, pulmonary washing and intensive antibiotic therapy both intravenously and orally. In between periods of hospitalization she was frequently put on many different broad spectrum antibiotics, Ventolin with Ental and cholemycin via inhaler. She was taking Pancrease M.T. 16 with meals for digestion.

In spite of this intensive treatment schedule Mary was getting constantly worse and the mother more desperate for help.

Presenting symptoms of this patient were:

1. Extreme difficulty in breathing with very audible moist rates.
2. Persistent moist, harsh cough productive of a very thick and tenacious sputum. She coughed so hard at times that she would vomit.
3. Severe coughing spells during the night, sometimes as long as 45 minutes duration with dyspnea and breath hunger.
4. Frequent muscle cramps in her legs.
5. Complete fatigue.
6. Very poor appetite with intermittent spells of constipation and diarrhea.
7. Constant anxiety that she was going to choke during one of her coughing spells.

Physical Examination revealed a very thin, hollow chested twelve year old girl with a very anxious expression and pasty complexion. Teeth were excellent, nails were moderately clubbed, lungs congested with moist rales and heart sounds were good. Mary's structure was very poor. She had may vertebral and rib lesions in the respiratory area of the upper thoracic with extremely tense and tender musculature in the entire thoracic area. Her color was slightly dusky and she displayed the appearance of a very sick young lady.

Laboratory work revealed a surprising normal C.B.C. with an R.B.C. of almost 5,000,000, Hgb. 14.2, W.B.C. 5,766 with a slightly elevated lymph count of 56%. Her thyroid profile was normal. Her SMAC was extremely abnormal with an Alkaline Phos. of 203, SGOT of 106, Cholesterol was only 104 and A/G ratio was 1.0.

The thing that shocked me the most was what this widely recognized specialist was encouraging this girl to eat. Her diet consisted of:

Breakfast: White bread with sugared cereal with added sugar and milk. Sometimes eggs and bacon.

Lunch: Steak, pasta, cheese, hamburgers with white bread and more milk.

Supper: Mostly a repeat of lunch.

Snacks: Cheese, milk, sugared peanut butter, cokes and candy. She was told NOT to take vitamins and in fact the doctor ridiculed their use.

Diagnosis: 1. Cystic Fibrosis 2. C.O.P.D. 3. Advanced Thoracic Somatic Dysfunction 4. Milk Allergy. 5. Systemic Candidiasis.

Treatment: Osteopathic manipulative therapy including vigorous thoracic pump procedure to stimulate lymphatic drainage, intensive intravenous drip therapy with 250 ml of Ringers, Lactate, 10,0000 mg. of Ascorbic Acid, 100 mg. of B Complex, 1,000 mg. of Calcium Gluconate, 200 mg. Magnesium Chloride, plus 2 ml. each of Glycyron and Gluthatione. This I.V. was dripped over a period of about one hour.

The mother was shown how to do the thoracic pump and was told to use it several times a day and especially at night when the coughing spells were so bad.

Diet was carefully outlined to the mother. It eliminated completely ALL MILK, CHEESE, COKES, SUGAR AND WHITE FLOUR PRODUCTS from her diet. She was told to eat eggs, chicken and fish, nuts, lot of raw fruits and vegetables (as well as lightly cooked vegetables), and only whole grain cereals and breads.

She was given a very high potency Vitamin and Mineral tablet, 3000 mg. of Vitamin C, 800 units of Vitamin E complex, a Calcium-Magnesium-Zinc tablet and Lipoplex caps. All of these on a daily basis at home. She was also given a prescription for Nystatin Powder to mix with water (1/4 teaspoon b.i.d.) to help her get rid of the obvious systemic yeast infection that she had from so many years of taking frequent antibiotics.

Progress: Mary's progress was absolutely amazing to her parents and very satisfying to me. One week after her first visit she returned and the following notes were made on her clinic record: "Progress is amazing for such a short period of time. Patient has not had any more antibiotics or used any more Ventolin. Breathing and eating much better. Bowel

movements much more normal. Cough has decreased markedly". Examination at this 2nd visit revealed most of the lung congestion had resolved. Her color was much better and she was no longer having to fight for her breath.

This patient continued to improve with each treatment which consisted of Manipulative Therapy and I.V. Drip therapy and on August 21st, just five weeks after her first visit, I made the following notation on her record: "Patient is progressing very well. B.M.s are almost normal now. Breathing is excellent. Sleeps all night now without coughing. Patient has no more bad spells of coughing. Energy level 100% increased. Patient can run and play with the other children now. Can take P.E. at school now." My last contact with Mary was several months ago and she was still doing well.

Comments: Such results as this in very long standing and chronic cases are not at all unusual when a combination of intensive nutritional therapy and Osteopathic Manipulative Therapy are utilized. My regret is that the doctors who have failed in the treatment of such cases as this, apparently have no interest in or even any curiosity as to what made the patient better. The medical profession (and I regret to say the Osteopathic Profession) is so inundated by pharmaceutical propaganda that we have a tendency to forget the basic tenets of Osteopathy and Natural Healing and accept that philosophy that drugs heal—and they don't. Most drugs should only be used as "crutches" until we can help nature heal the patient. ▲

If you are distressed by anything external, the pain is not due to the thing itself, but to your estimate of it; and this you have the power to revoke at any moment.

—MARCUS AURELIUS
(121-180)

LETTERS TO A.T. STILL

Dear Dr. Still,

It's interesting to talk to osteopathic physicians and find out what they think of the term "Osteopathy". My impression is that a lot of them don't pay too much attention to this topic, but others are more passionate about it. Some think we should have maintained the use of the MD title, some propose titles like MDO; some wish you had used an entirely different word besides "Osteopathy" to describe your system of practice.

Andrew Taylor Still

I think the biggest problem is that the public tends to think of the term "Osteopathy" as meaning "Bone disease", and therefore that osteopathic physicians only treat bone problems, or at best, musculoskeletal problems. This does cause us to have to take more time to explain to people how we're trained and what we're really capable of doing. Sometimes it's frustrating, but it's never an excuse to not explain the profession to someone who's interested in hearing about it. For those DOs who get tired and frustrated with this, it would be good for them to read your books and find out what you really were thinking when you coined the term "Osteopathy". For example, on page 184 of your book, Autobiography of A. T. Still, you had this to say: "You wonder what Osteopathy is; you look in the medical dictionary and find as its definition 'bone disease.' That is a grave mistake. Osteopathy is compounded of two words, osteon, meaning bone, pathos, pathine, to suffer. I reasoned that the bone, "Osteon", was the starting point from which I was to ascertain the cause of pathological conditions, and so I combined the "Osteo" with the "pathy" and had as a result, Osteopathy." So it makes sense that the bones form the innermost part of the body's structure, and is a good place to start looking for the structural problems that lead to physiologic discord in the body.

You emphasized this point even further in your book, The Philosophy and Mechanical Principles of Osteopathy. On page 86 you said, "Efforts at restoration from the diseased to the healthy condition should present but one object to the mind, and that is to explore minutely and seek the variation from the normal. The first search for this knowledge would confine us to the bony system, in order to see if any lesion presents itself by any abnormally large place or places."

This information has always been of enormous help to me. Perhaps if more DOs read these passages and reflected on them a little, they would find that it suddenly isn't so difficult to understand the meaning of the word "Osteopathy."

Your ongoing student,

Raymond J. Hruby, D.O., F.A.A.O.

The Value of Some Clinical Tests of the Sacroiliac Joint*

L. L. J. M. van Deursen, J. Patijn, A. L. Ockhuysen and B. J. Vortman

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Institute for Manual Medicine, Eindhoven, The Netherlands

Summary. Several tests have been developed in the past for evaluating the existence of a block in the sacroiliac joint. To investigate which test was clinically most valuable, we random-tested 45 patients. Six of the most frequently used tests were performed on each left sacroiliac joint, without comparison against the right side. Each patient was independently investigated by three different highly skilled physicians. Intraobserver agreement of the different tests was examined. The diagnostic value of most tests was surprisingly low in this investigation.

Key words: Sacroiliac joint – Random tests – Diagnostic value

Specialists in manual medicine consider that sacroiliac (SI) joint dysfunction, in particular sacroiliac joint blockage, is a common cause of low back pain [3, 6, 9, 14, 15, 19]. How frequently this is assumed, is shown for example, by a report of SI investigation that appeared in *Manuelle Medizin* in 1985: among 1344 patients with back disorders, a diagnosis of sacroiliac joint lesion was recorded in 467. The diagnosis "SI blockage" is based mostly on acceptance of the positive outcome of some of the numerous SI tests or signs.

In the article mentioned above, the diagnosis was accepted when 7 out of 13 special SI joint tests were positive [19]. Many more SI joint tests than these 13 have been mentioned in the literature [9, 14]. Some of the signs are based on the pelvic position as a feature of blockage, while other signs and tests are based on mobility disorder, pain irritation zones or muscle reactions. In view of the different opinions with respect to the pelvic position as a sign of SI blockage, the doubts about the validity of those tests and signs are understandable [2, 13, 15, 16]. Despite the controversy, all large-scale investigations suggest that an SI blockage is quite easy to diagnose.

But in spite of this easy diagnosis and its frequent occurrence, it is surprising that there still seems to be no uniform opinion on either the "symptom pattern" or the clinical features of an SI blockage. This could reflect the existence of different types of SI blocks, but it could also demonstrate our problems with the diagnosis. During our panel consultations we have also met disagreement over the diagnosis of SI blockage, which causes difficulties with the diagnostic and therapeutic procedures.

It is therefore necessary to consider how reliable the clinical tests in use are; how reliable the diagnoses made with their aid are; and whether they are as fool-proof as suggested.

In the literature we have found only one minor study into the intertester reliability of some clinical tests of the SI joint, and this reliability was proven to be poor [17, 18]. The authors suggested further investigation and clinical study. For all these reasons we started our investigation into the value of some clinical tests of the SI joint.

Materials and methods

Two groups of 45 patients with low back pain were examined. There was no special selection. The only patients excluded were those with acute low back pain caused by discopathy or radicular problems. All patients were examined independently by three physicians, who enrolled patients in the trial at random. These three physicians are well-skilled in manual medicine. They have all been working full-time in our manual medicine clinic for an average of 8 years and regard SI investigation as daily routine. All three are also members of the Dutch educational board, so we thought the situation was ideal for this trial.

In the first group of 45 patients the physicians were asked to perform six selected SI tests on the left SI joint only. No further examination or anamnestic procedure was allowed. In addition to performing these six tests, they were asked to give a final conclusion on whether the left SI joint was blocked or not. This conclusion was to be based solely on the results of these tests. The tests were performed on only one side because in a pilot study we found that performance of these tests on both sides gave rise to errors. Moreover, we know that our tests are mostly formulated as specific for the SI joint in question, so that it seemed justified to examine only one side. We selected the following six tests for this trial:

Offprint requests to: L. L. J. M. van Deursen, Institute for Manual Medicine, Stratumsedijk 26, NL-5611 ND Eindhoven, The Netherlands

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- Overtake (Vorlauf) phenomenon
- Spine test
- Patrick's sign
- Lateroflexion test
- Flexion-adduction test
- Translatory investigation

These tests are explained further below.

Since the pelvic position is still not by everyone considered a feature of blockage, we preferred to investigate blockage only by means of movement disturbance tests, because these are generally accepted as a proof of SI blockage.

Overtake phenomenon, spine test and Patrick's sign are the most widely used SI joint investigation tests reported in the European literature. The lateroflexion test was chosen because it seems to be so easy that it is one of the first tests our students learn. Flexion-adduction is often used for testing the movement disturbance through the reflectory muscle spasm normally present in SI-blocking. This phenomenon is also said to be reliable and easy to discover. The translatory investigations is a more specific osteopathic method of examination, which is often used, always mentioned and always done in our clinic.

The second group of 45 patients was also independently investigated by the same three physicians. In this trial they had complete freedom to investigate the left SI joint in their usual way. They were only asked to say whether there was a left SI joint blockage or not. All data were statistically analysed.

Short explanation of the tests used

1. Overtake phenomenon from a standing position. In this test we are trying to find the overtake phenomenon. The investigator sits behind the standing patient with the thumbs on the patient's two SIPS (Spina Iliaca Posterior Superior). The patient is asked to bend forward slowly as far as possible.

A positive overtake phenomenon means that in one thumb the movement is perceived as starting earlier, and at the end of the movement this thumb is found to be in a higher position than the other and to remain there.

It is assumed that the SI on the side of the positive overtake is blocked or that there is pathologic hypermobility on the other side [5, 8, 12].

2. Spine test. A frequently used test, described by Kirkaldy-Willis and Hill is the spine test [10]. During flexion of the hip, with the patient in a standing position, the displacement of the SIPS against the sacrum is monitored. This test can cause practical problems, especially for the elderly, and in such cases an elegant version based on the same principles (described by Dejung [4]) is preferable. In this version the patient is not asked to flex the hip, but rather to bring one knee forward as far as possible. Thus, this test is practically equal to the so-called hip-drop test.

The investigator sits behind the standing patient with one thumb on an SIPS and the other on the crista sacralis mediana at the same level. The patient is asked to perform a maxial knee flexion on the side of the palpated SIPS, while keeping both feet on the floor.

If the SI joint is not blocked the ilium will move downward and rotate slightly in a dorsal direction. The angle between the body axis and the line through the investigator's thumbs should become greater than the original 90°. If it does not, there could be a blockage on the side in question.

3. Patrick's sign (In German: Viererzeichen). The patient lies supine with one leg flexed so that the heel on that side is next to the other knee. The patient is asked to press the flexed knee outwards, and this movement is passively enforced. If this movement is restricted, the test is said to be positive. If the hip mobility is normal this also reflects on the condition of SI joint [5, 6, 8, 12].

4. Lateroflexion test. The investigator sits behind the standing patient with both thumbs on the patient's two SIPS. The patient is asked to bend to one side. The investigator then has to judge whether the SIPS on the convex side is going down or not, and whether it is in a lower position than the other at the end of the movement. Normally this will be the case [7].

5. Flexion-adduction test. This test exploits the supposed reflex hypertonic reaction of the muscle during SI blocking. Reflex shortening of the gluteus maximus and piriformis muscles restricts the flexion and the adduction of the hip.

6. Translatory investigation. For this test the patient lies supine. The hip and knee on the side being investigated are flexed just over 90° and held in place with one hand by the investigator, who palpates the SI joint groove with the other hand while exerting pressure on the flexed leg, with short impulses in an axial and slightly adducted direction. A practised and experienced investigator can feel the difference between normal and blocked movement [12].

Results

The first trial yielded quite a large body of data: the results of the six tests performed in 45 patients and interpreted by three physicians and the assessments of all three physicians as to whether left SI joint blockage was present or not.

These data were used to formulate and answer the following two questions:

1. Do the three physicians interpret the results of the six tests in the same way and is there any agreement among their diagnoses?
2. Are the six tests good predictors of the diagnosis?

In answering these questions concerning agreement in the classification behaviour of investigators, we make use of Cohen's kappa test [1], which is the conventional measure of concordance between investigators. Kappa is the proportion of agreement determined, corrected for agreement by coincidence. This seemed the best method to use, as our main aim was to determine whether the agreement was adequate overall.

Normally a kappa value of 0.20–0.40 is considered "fair"; 0.41–0.60 "moderate"; 0.61–0.80 "substantial"; and 0.81 and more "almost perfect" [11].

Table 1 shows the answer to the first question, i.e., the agreement (kappa) between pairs of physicians in classification of the results of the six tests and their own conclusions; there are few kappa qualifications that could be called even "fair". The negative kappa outcome says that the agreement is even less than would be expected to occur by coincidence. So there is not even minimal consensus. This goes for all tests and also for the physicians' own diagnoses.

Table 2 shows the predictive value of the six tests for the physicians' own diagnoses (intraobserver agreement). We have to ask whether physicians always use the test outcome in a consistent manner to reach their conclusions?

Table 2 shows that tests 5 and 6 are the most reliable individual predictors of the conclusion, made by the physicians. This means the highest intraobserver agreement, which is "perfect" in the case of test 6 for all three physicians; unfortunately, however, this does not concur

Table 1. Agreement between pairs of physicians in classification of results of and their conclusions

Physicians	Tests						Physicians' own diagnoses
	1	2	3	4	5	6	
A and B	0.11	−0.08	−0.05	0.29	−0.16	−0.05	−0.05
A and C	0.08	0.10	0.38	0.20	0.06	0.14	0.14
B and C	0.03	−0.16	−0.23	0.05	0.13	−0.09	−0.09

Table 2. Agreement of the six tests for each physician and the predicitive value

Test	Physician	Test						Physicians' own diagnosis
		1	2	3	4	5	6	
1	A							0.61
	B							0.23
	C							0.21
2	A	−0.09						−0.22
	B	0.02						0.19
	C	0.36						0.32
3	A	0.25	−0.01					0.18
	B	0.34	0.17					0.21
	C	0.36	0.22					0.24
4	A	0.34	−0.29	0.25				0.43
	B	0.06	−0.05	0.15				−0.15
	C	0.22	−0.01	0.36				0.22
5	A	0.61	−0.12	0.28	0.43			0.89
	B	0.33	0.39	0.34	0.01			0.52
	C	0.10	0.21	0.21	0.32			0.84
6	A	0.61	−0.22	0.18	0.43	0.89		1.00
	B	0.23	0.19	0.21	−0.15	0.52		1.00
	C	0.21	0.32	0.24	0.27	0.84		1.00

Table 3. Agreement between pairs of physicians in their conclusions the left SI joint following free investigation

Physicians	
A and B:	0.20
B and C:	0.60
A and C:	0.50

with interobserver agreement, as shown in Table 1. The mutual agreement of the six tests allows individual prediction of the outcome of a test when the outcome of another test is known. There is only almost perfect agreement between tests 5 and 6. Only for one physician was substantial agreement found, between tests 5 and 1 and tests 6 and 1. All other agreements were less than moderate.

In the investigation of the second group of 45 patients, in which three physicians dediced independently whether in their opinion there was SI block on the left side or not, the agreement varied between just fair and almost substantial; on average it could be called moderate (Table 3).

Discussion

The results of the first examination confirmed our suspicion that the reliability of these six frequently used SI tests was doubtful. We had not suspected that it was as low as it turned out to be. No agreement was found in any of the six tests in the investigators' own conclusions based on these tests. Our results confirm the results of another published investigation on intertester reliability for selected clinical tests of the SI joint [17]. This investigation was conducted in only 17 patients by pairs of physiotherapists. They also found very low agreement, even for the determination of pelvic landmark levels in standing and sitting positions. They also advised further study to examine critically how the SI joint can be reliably evaluated clinically. Indeed, these results cast doubt on the validity of investigating of the SI joint in this way, and on the value of these SI joint tests in particular. The conclusion has to be that the value of these six tests is not as high as suggested in the literature.

On the other hand, we are all convinced that these tests do have a certain value. It could be possible that the style of testing applied in our first group is still too artificial and that the value of these tests will increase when

combined with other findings in the diagnostic procedure. Our second investigation showed indeed that when physicians were free to chose the examination procedure, the agreement of diagnoses increased. The agreement then found was low to moderate. This could mean that information other than that yielded by the tests could have been more important. It would be interesting to know what precisely the physicians did in the second part of the study. Surprisingly, they did less than in the first.

Physician A did only flexion-adduction and translation, physician C did flexion-adduction and translation and checked the end-feeling in extension lateroflexion in standing position; physician B did flexion-adduction, translation and overtake phenomenon and also checked end-feeling in lateroflextion and in extension lateroflexion, and he also asked about pain. In general, however, all did much less than in the first part, and apparently elicited correspondingly less information. It cannot be therefore that supplementary led to the better agreement. One possible explanation could be that an SI blockage is not as static as we think it is, and that there are far more dynamic SI problems than are currently known.

We all know that pelvic distortion can result from a block elsewhere in the spine, mostly the cervical spine [2, 13]. It has also been shown that in pelvic distortion there is a "false", meaning only temporary, positive overtake phenomenon and spine sign [12, 13]. Mostly it is reported that these false-positive tests become negative within 20 s. Within a certain period a false-positive test does not seem to be reproducible. It seems possible that the same applies to all the other signs and tests. Performance of only two or three tests may be little enough not to cause any disturbance of the temporarily positive tests. Thus, if little is done or a long enough waiting period is observed the agreement could increase. This could explain the better results in the second group. Performance of a large number of tests could lead to different findings, especially if little attention was paid to false-positive test results. Our conclusion has to be that there are many more cases of dynamic pelvic distortion, or that an SI blockage is much more flexible, than we think. It seems we need to be much more critical and that further investigations have to be conducted with more attention to false-positive test results and to pelvic distortion. Perhaps then better, or even "perfect", agreement will be achieved.

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Coming up... The American Academy of Osteopathy's 1992 International Symposium

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Also discussed will be: Sympathetic modulation of the immune system, Adrenal Steroid modulation of the immune system, Nociception and neuroendoctrine-immune system modulation, Stress and body physiology, Stress and body psychology.

Look for more information in the next issue of the AAO Journal.

THE TIGHTROPE WALK OF OSTEOPATHY

by Andrew Ferguson, D.O., M.R.O.

The point of this essay is to help us to see more clearly some dilemmas that we as Osteopaths face both within and without the profession and, as a result, perhaps help us to progress. Osteopathy walks a difficult, shifting and hard-to-define tightrope between various apparently opposing concepts and ideals. Where the line is drawn between these concepts depends on the viewpoint of the line drawer. Walking the line gives Osteopathy great potential for balance and breadth of vision.

STRUCTURE vs. FUNCTION

One way that this dilemma can be represented within Osteopathy is in the classic debate between the roles and importance of structure and function in the biomechanics of the body. The two are, of course, completely interdependent. Structure is not alive without function, function is not real without structure. Over its history Osteopathy has varied between a more structural bias, such as concentrating on fixing bones out of place and the saying structure governs function, and a more functional bias, such as in studying tension and motion and ideals like Laurie Hartman's function governs comfort and Peter Randell's structure is rigidified function.

Osteopathic technique has evolved among similar lines, broadly split into more structural approaches such as high-velocity thrust work and the forceful unlocking of binds and more functional work such as relaxing, easing and gentle releasing techniques. As Philip Latey points out, we cannot employ one without the other. Structural technicians need to relax and lull the patient before their maneuvers and functional technicians also use commanding moves that may be more physiological than anotomical in nature but are, nonetheless structural if they are intended as specific interventions into a system.

Individual Osteopaths hold views that are somewhere in the continuum between structural and functional with individual biases one way or the other. Being able to see and feel both aspects simultaneously is better.

A similar split is present in the argument about the role of the mind and emotions (phyche) in the body (soma). On the whole Osteopathy has tended to be biased towards the somatic side of the fence, along with most modern Western medical attitudes, to the schism. There is increasing evidence for and acceptance of the views that put the psyche as the most influential side of the psychosomatic divide. It is, however, another tightrope situation along which Osteopathy is in a position to walk. It has all the characteristic features: 1) The two apparent opposites are interdependents; 2) There is no easy dividing line between them. They are a continuum, so any division is bound to be artificial, arbitrary, subjective and depend on one's viewpoint; 3) It is often easier to be polarized toward one camp or the other, often the one with more people with firmer views. The more difficult position is in the middle.

WALKING THE TIGHT-ROPE

Walking the tight-rope or being in the middle are not the same as sitting on the fence, at least not in the sense that implies passivity and indecision. Perhaps we have a sociological bias or suspicion of fence-sitters that leads it to be taken as a derogatory phrase. It could be seen in a more positive light of being balanced, courageous and able to see both sides of the argument rather than being restricted to one view and being reinforced in that view by colleagues with similar views. Being on the fence does, however, provide a clearer target for attacks from both sides.

SCIENCES vs. ART

An extension of this physiological tightrope to broader issues brings in the long-running debate whether Osteopathy is a Science or an Art. There are vociferous arguments on both sides and the Osteopathic answer is that we are, and need, both. Science gives us security in our knowledge, the potential for improving understanding in ergonomics, safety and many other areas and some solid foundations upon which to base our judgments. Yet even science needs original thoughts and ideas, creativity and intuition, to make real progress or leaps of discovery. Without this art, science is dead.

The art, intuition, feeling and flow of Osteopathy is a vital part as we dodge and weave through our life and practice. People as individuals can rarely be put into a few categories. Diseases or problems can be clearly labeled only when extreme (when it is often too late and they need extreme treatment). The art, skill and care of Osteopathy are vital components yet without a foundation or science this could be anarchic, aimless, non-progressive and destructive. There are many benefits that derive from a thorough training that gives us scientific knowledge and logical deductive reasoning as well as art, skill and empathy.

AUTHORITY vs INDIVIDUAL EXPRESSION

The tightrope walk of Osteopathy may also extend to the position in which Osteopathy has tended to be throughout its history. Authority, or the Establishment, tends to be rigid and reactionary and not readily accepting of challenges or different viewpoints. Individual expression

about health and disease tends to be stifled by authority yet needs some sort of collective organization or society. Both need each other: extremes are always unbalanced and dangerous. Osteopathy can be uncomfortably caught in the middle not wanting to betray either side. Perhaps the choice of Osteopathy as a profession tends to be made by those who prefer more individuality than the establishment permits — thus Osteopaths are not likely to conform totally, even with each other!

Authority is often represented by the medical establishment. Individual expression is represented by the needs of individual patients and perhaps therapeutically by some of the fringe or more esoteric belief systems. Individual Osteopaths tend to veer more to one side of this fence or the other — some like to be fairly establishment orthopedic physicians while some like to dabble in a mixed cocktail of often bizarre beliefs. In general, Osteopathy in Europe seems to be steering a middle course with all its disadvantages and advantages. As a result of doing that it is helping the two positions to become less polarized and see the pros and cons of each philosophy. Medical doctors are becoming more concerned with the individual and becoming aware of the potential harm and limitations of some of their therapies. Fringe therapies are beginning to see the benefits of some solid foundations in expertise and training. Osteopathy should continue walking the tightrope until there is acceptance on both sides without, however, losing sight of the impatience and benefits of either.

OSTEOPATHY - A BALANCED VIEW?

We could substitute many other apparent opposites, both within and around Osteopathy. Debates such as Male vs. Female (it is good that the profession is almost equally balanced in the UK), Pure-cranial vs Anti-cranial, Involvement vs Detachment, Verbal vs Non-verbal techniques and Visceral vs Musculo-skeletal are all part of the Osteopathic mix. It is good that there is a wide range of individuals within Osteopathy exploring and developing in their own ways — mainly in functional manner. We have not evolved a rigid structure of ways to behave or role models and stereotypes to which we must conform, yet. Perhaps this is just as well.

We walk with a difficult path and the questioning reader will find few answers here save the encouragement to ask questions, stand up for your views, listen to the views of others and be confident that you are not walking alone. If you feel that you need to step off the tightrope, make sure that you don't do it on both sides at once. The results could be painfully self-divisive! ▲

National Osteopathic Medicine Week, September 22-28

Osteopathic Medicine: Offering A Cure for What Ails US

NATIONAL OSTEOPATHIC MEDICINE WEEK
SEPTEMBER 22-28, 1991

MEDICARE & CODING TIPS

by Don Self, Medical Consultants of Texas

HFCA'S ANSWER ON 90030

Per Kathleen Buto (Dir. HCFA Policy Development - Ltr dated 7/11/9): A physician may not bill for a separate office visit due to a patient returning for clinical laboratory test(s), as the interpretation of the test(s) is included as part of the previous office visit(s). The physician may not be separately reimbursed for telephone calls to the patient to discuss the results of said laboratory test, as this is also included in the payment for the previous office visit(s). They are not allowing a physician to bill a minimal office visit, unless the physician is "present in the office suite & immediately available to provide assistance & direction throughout the time the employee is performing services". Basically, they are forcing physicians to have the patients come back to the office for lab results (thereby allowing the physician to charge a separate office visit), since they will not pay for telephone calls from the physician to the patient. They are also forcing the physician to be present in the office (not necessarily in the same treatment room), when blood pressure checks, injections and minimal services are billed for (using code 90030). Since we do not agree that all clinical lab interpretations are part of "previous office visit recompensation", we are writing to the Director of Health & Human Services, as well as our Congressman and Senators about this. We encourage you to do the same.

MEDICARE SECONDARY PAYER FINES

Congress is calling for HHS to start fining physicians for filing Medicare as primary whenever the patient has a private carrier and Medicare should be the secondary carrier. In the past, they have tried to track down the secondary carriers and retrieve the money (more than $1 Billion per year) from the insurance company. The House Ways & Means Subcommittee wants the IG (Inspector General) to start penalizing physician offices in the near future fines up to $2,000 per occurrence. They want the offices fined for not "screening" Medicare patients for private insurance, repeated submissions of primary (private) claims to Medicare and double billing (submitting to Medicare & private carriers). It is very likely this will occur and there is a good chance physicians will be caught without warning.

EASIER LAB REGS COMING

Docs that rely on automated lab equipment to perform multiple tests in their own offices could end up with clinical lab regs that are much easier to live with, than those originally proposed by HCFA. The solution may be a special status for automated devices than CLIA originally allowed. Apparently, enough physicians wrote to HCFA & Congress that proposed CLIA labs would force them to cease lab billing and send patients to Independent Labs, causing unnecessary hardships on Medicare beneficiaries. The FDA & Centers for Disease Control still need to agree that the devices used by physicians are sufficiently accurate.

OBSERVATION PAY INCREASING

Currently, physicians are "penalized" with a 40% reduction in their payments when they perform mostly office based services in hospital outpatient facilities. Using Codes 90000-90080 in the hospital outpatient department for "observation" visits nets you a 40% reduction in what you are paid, if you used the same codes in the office, since you do not incur the cost of supplies and overhead in the hospital. Under the just-proposed Medicare fee schedule, HFCA is considering raising the rate of pay from 60% (of what you are paid in the office) to 80%, by adjusting the practice expense relative values. How this works out still remains to be seen.

INJECTION PAY IS THREATENED

The Medicare fee schedule proposal also eliminates payment for administering a subcutaneous, intramuscular, intravenous and intra-arterial injection, when a visit is billed for. The proposal does not include administration of Chemotherapy injections. What the fee schedule does not address is the trigger point injections (20550) and arthrocentesis injections (20600 - 20610). Payment for the drugs would be set at 85% of the national average wholesale price of the drug in 1992, compared with the current policy of base pay for drugs based on the wholesale price guides. An HHS Inspector General report shows pharmacies getting 15.9% discounts off the wholesale price and HCFA believes that physicians can demand the same discounts. Assuming this takes place (and you get 15.9% discounts), this would leave you with a profit margin (if there is any) of only .9% on any injection. This does not take into account the expenses associated with ordering, obtaining, or storing the drugs. Nor does it take into account the malpractice liability, cost of needles, alcohol, syringes, and other materials and supplies needed, as well as the disposal expenses of the same. We strongly suggest that you immediately respond with a letter to the HHS, HCFA, your Medicare carrier, and your elected officials concerning this. ▲

> The greatest discovery of my generation is that a human being can alter his life by altering his attitudes of mind.
>
> —WILLIAM JAMES (1842-1910)

TEDDY

by Margaret W. Royson, D.O.

Teddy, Little Teddy, I miss you. Those eyes, so large and white in comparison to your brown little body of 56 pounds. Those spindly arms and legs so contracted, so awkward, so distorted, the shape of reverse L's and hyperflexed A's. How your little heel was flattened up under your bottom, twisting your torso so that we thought you would break in half.

How scarred your skin was from 32 years of cut-downs, central lines, IV's and feeding tubes. How old and well tunneled was your tracheostomy that you could breath without the apparatus when it was found on the floor that time. How you hated your bindings when they tied those twisted arms to the bed, immobilizing one of the only ways you had of communicating.

How strong and fierce you were when you pulled on them trying to get us away from you when we were there to poke you again for blood. But, you had those eyes. We could not take those away from you. You could use them to yell at us. "Get away. No more!"

How your eyebrows would furrow and your mouth would curl when you saw us coming. How you knew we were here to inflict pain again and again and again and again. How you would dart your eyes at the harsh voice and send poison through them and show your crooked teeth and they would call you exorcist and laugh.

I wished at those times that I could take you away for just a weekend and prop you up in the front seat of my car, with the window open, on a beautiful sunny day so you could feel the fresh air blow on your face. And you would be able to see trees and people and animals and things.

I wanted to put you in a pool of water and let you feel the velvet on your skin and swirl you around so you could know the comfort, for just once, of lulling waves rocking you in their cradle. I wanted you to feel the sun on your body, something warm and enveloping. I wanted you to be unbound and able to explore your surroundings, to learn to trust enough to let the world in through those eyes instead of using them as weapons to keep it out. But, of course, none of this would ever be yours, my little Teddy.

But, perhaps I could use my voice and mind to tell you of this. Would you let yourself be given to? When I told you how pretty you looked and stroked your cheek, how startled you appeared as if to say, "What is this strangeness I am experiencing". How open your eyes were. How stunned and still you were. How you stopped writhing in your snake-like pattern as if waiting to see if this were real and would it go away or stay. But, it was still there, a soothing smoothness on your cheek and a voice that was soft and full of as much love as was ever possible.

How readily you lent yourself to this as if having found an oasis in your parched desert of experiences. It took you no time at all to heave a huge breath and half close your eyes and then go off to sleep.

How innocent and dear you looked this way. I loved our daily visits. I would look in on you at night when I was on call just to send you another "love balm" and thank you forever for teaching me that here is always hope, that no life is over until it is done. ▲

<Ed note> Teddy, who had been born with hemolithic disease, died shortly after this essay was written.

Proposed Legislation Could Ease Medical Malpractice Crisis

by Micheal S. Mullen, J.D.

In California, one third of the physicians no longer deliver babies. In Texas, the figure is closer to 40 percent. In Utah, more than half of the general and family practitioners have stopped providing any pregnancy-related care at all. And , in Florida, more than 1,000 medical specialists fearing lawsuits have refused to work in emergency rooms.

During the Mid-80s, rising costs and the fear of liability suits created a medical liability crisis that is forcing doctors to refuse to treat patients, hospitals to close their doors and manufacturers to pull new, potentially life saving drugs off the market. Although the situation has eased because of insurance companies who have been driven to extreme cash flow pricing by their falling solvency situation, the underlying problem of ever increasing loss costs will soon bring about the next medical malpractice "crisis."

In recognition of the problem, Senator Hatch (R-UT) and Representative Johnson (R-CT) have introduced a bill combining federal efforts with state initiatives designed to help alleviate the situation which costs the health industry anywhere from $19.3 - $100 billion in related expenses each year. The bill, "Ensuring Access Through Medical Liability Reform Act," is designed to restore equity, access and justice to the nation's medical malpractice system while improving the quality of health care by:

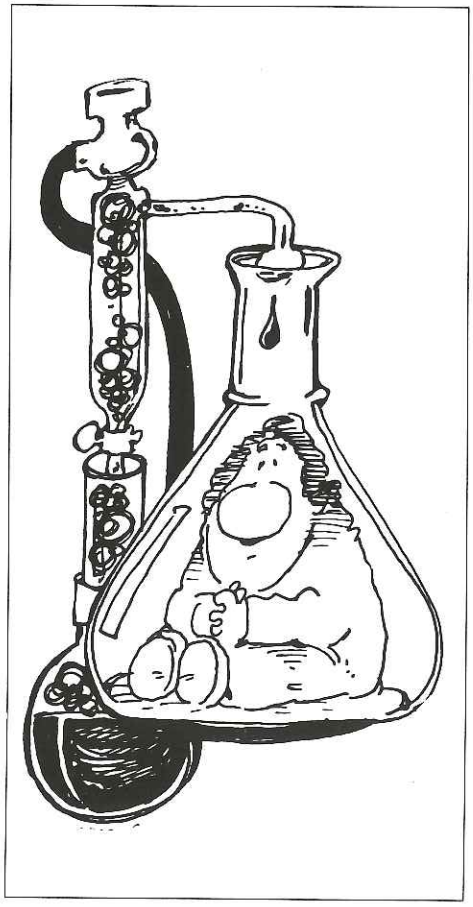
- Strengthening state licensing and disciplinary agencies so they can provide quick, remedial and punitive action when a care provider is found negligent;
- Requiring comprehensive medical quality assurance and risk management initiatives among health care providers to assist in preventing avoidable patient injuries;
- Establishing a risk retention group to provide liability protection to health care professionals serving community and migrant health centers;
- Awarding grants for state programs to educate health professionals and the public in medical liability tort reforms; and,
- Awarding grants to states to determine the most effective way medical liability claims could be handled to resolve the claims faster and more fairly

The bill also includes some specific tort reform measures including: placing limitations on non-economic damages; considering collateral sources in settlements; limiting attorney contingency fees; making periodic payment mandatory in large settlements; and revising the statutes of limitation. Introduced in Congress on February 26, the bill has been referred to the Committee on Labor and Human Resources. Hearings have not yet been scheduled.

In introducing the legislation Hatch said, "Clearly we have a medical liability problem that must be addressed. The time has come to stop debating whether there is a problem and to admit that medical liability has had a decidely negative impact on American's access to quality health care. We must move forward now to enact solutions."

Although the liability nightmare affects all sections of society, its impact on America's health delivery system is the most frightening. Imagine being a critically ill patient transported from hospital to hospital searching for a doctor willing to treat you — willing to risk the possibility that their career will be ended by a lawsuit. That is exactly what happended to a six year old Florida boy hit by a van and turned away by seven hospitals in North Miami Beach because only one hospital in Dade County was staffed to treat trauma victims that day. The boy was fortunate enough to survive the incident, but will the next person be so lucky?

The sad fact is that many doctors have decided they can no longer risk a malpractice suit by performing emergency room surgery. These doctors see firsthand how litigious our society has become. For example, in 1986 alone 86 percent of Florida's neurosurgeons were suited, and, according to a survey recently conducted by the American College of Obstetricians and Gynecologists, 77.6 percent of the OB/GYN doctors who responded indicated they have had at least one professional liability claim filed against them. It is difficult to believe that all these doctors are in-



competent and deserve to be suited. There can be no question that our legal system simply will not satisfy the demands placed upon it in the 1990s. Unfairnesses abound on all sides of litigation, not only to the defense. For example, patients who are truly injured in the course of medical treatment deserve to be compensated promptly and fairly. Unfortunately, that it not what happens today. Instead, the plaintiff usually spends years and thousands of dollars to press a suit. Of the amounts paid in malpractice premiums by physicians, as little at 25 percent actually goes to the injured victim. The rest goes to the system: lawyer's fees, court costs and other legal expenses. Clearly, our tort system has become a lottery, providing large windfalls to a few victims without regard to the real losses involved, discouraging the claimant with the small claim from prosecution, all the while costing everyone involved huge sums.

It is unfortunate that the various states have refused, in large part, to listen to the voice of reason sounded by physicians groups and medical societies. Had necessary reforms been implemented five years ago the federal government would not be faced with solving this problem.

This legislation is designed to restore the balance between providing civil resource to consumers with returning a sense of fairness and balance to our legal system. Whether it is this bill or another incorporating significant tort reform, whether at the federal level or the various states, we need those reforms now — before more life saving drugs have been removed from the marketplace, before more doctors leave their practice and before even one life is lost because a physician facing the threat of a lawsuit refuses to treat a patient. ▲

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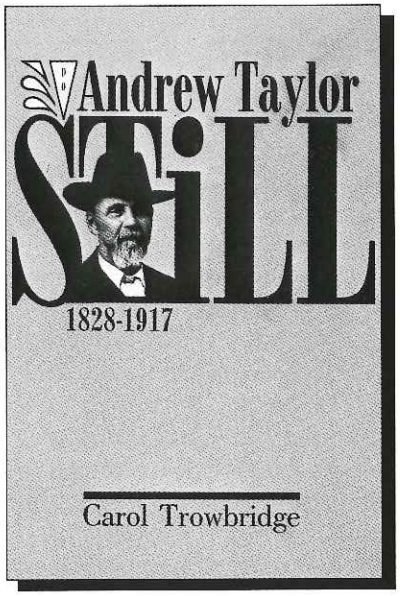


A.T. Still - 1828-1917

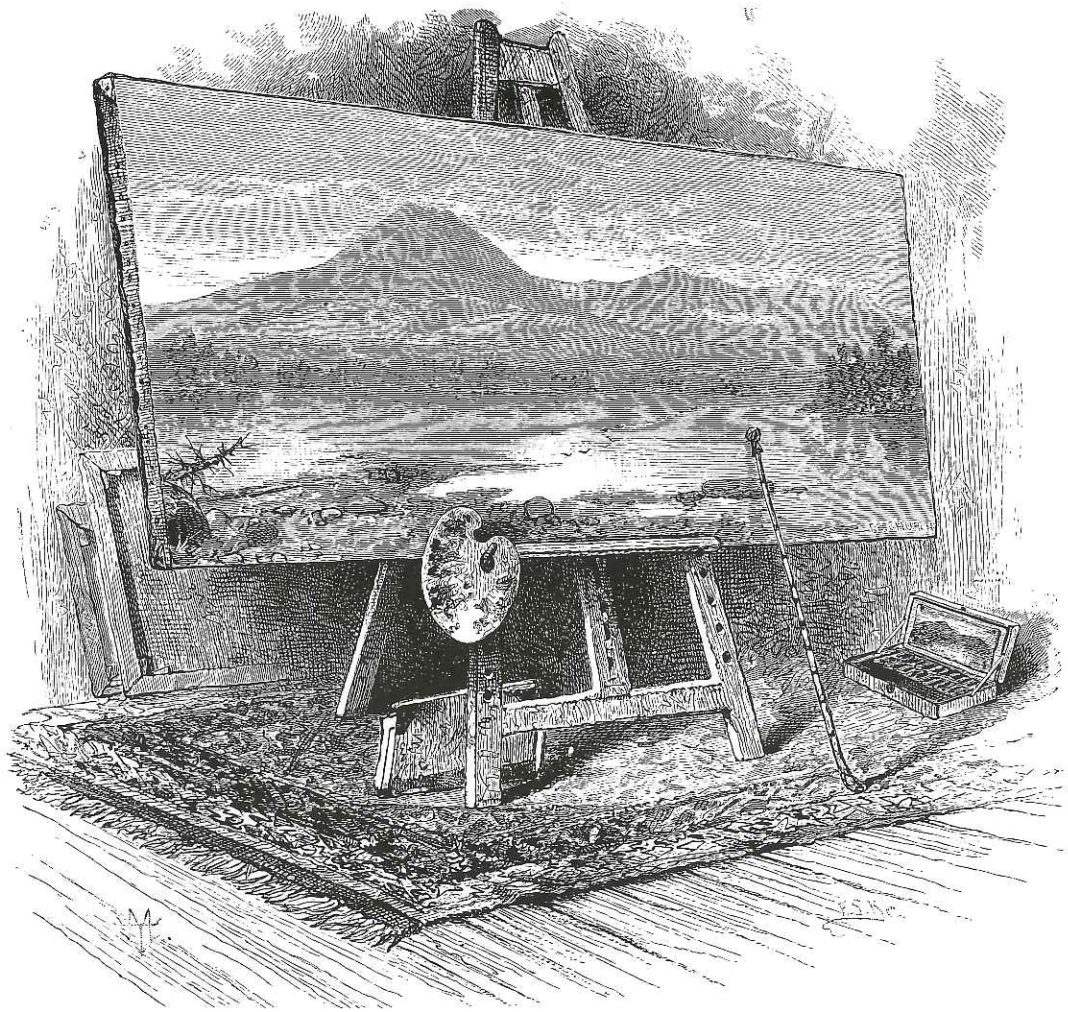
Book Review By J.L. Dickey, D.O.

by Carol Trowbridge

Mrs. Trowbridge has done the osteopathic profession a great favor in writing this book. She is a lay person who became interested in the osteopathic profession when her husband took a position with the Kirksville College of Osteopathic Medicine in the mid 1970s. Mrs. Trowbridge worked in the Still Osteopathic National Museum from its inception until her move from Kirksville, and became fascinated with the life and history of this profession. She has done exhaustive research over the past ten years and has put together a wonderful volume with the help of the late Mary Jane Denslow, Dr. Still's granddaughter. This book contains information that heretofore was unavailable. She paints a beautiful picture of the life and times, not only of A.T. Still but also of his parents. She weaves a historical novel through the first part of the book, showing his developmental years, the various moves that the family made and influences upon him. In Part II of this book Mrs. Trowbridge discusses the major philosophical movements that were swirling around in the mid-nineteenth century. We see A.T. Still's contribution to the healing arts within the context of his times as a original thinker and a person moved by the major philosophical and physiological movements of his day. We get a picture of a true seeker, a searcher for truth; and osteopathy was A.T. Still's answer to his many, many questions. This book has given me personally a better understanding of the philosophical underpinnings of osteopathy. We see this as a logical outgrowth of the perfectionism inherent in the Methodist philosophies that Still grew up with, combined with the surging philosophical upheaval that evolution brought in the late nineteenth century. This helps to explain much of the language in Still's own books and gives a better understanding of how he thought and why he thought what he did.

For some the price tag of $50 may seem steep, but this publisher is unsure of the audience to be reached. Even at this price, this book is well worth it. It should be in the library of every osteopathic physician and should be required reading for all osteopathic students. I heartily recommend A.T. Still - 1828-1917. ▲

Book may be ordered through the T. J. University Press, Northeast Missouri State Univ., Kirksville, MO 63501 (816) 785-4156



I Had a Dream . . .

by Laurie B. Jones, The Jones Group

The other night I had a dream....

That DOs were hosting world wide symposiums to educate other health care professionals and expand the awareness of osteopathic medicine.

That every professor in every osteopathic college clearly understood and proudly taught osteopathic principles.

That pre-med advisors steered the brightest and the best students towards osteopathic colleges, rather than away from them.

That every newborn baby was required to have a cranial exam.

That every woman in labor received OMT.

That every pre-op and post-op patient received OMT.

That the AOA held an annual vision quest inviting health care leaders within the profession to brainstorm new directions.

That the AOA had a board of advisors which consisted of "out-siders" friendly to the profession who had national and worldwide prominence, prestige and expertise in the delivery of health care to the public.

That a documentary on AT Still was aired on PBS.

That CNN carried features of osteopathy's proudest and the best, emphasizing the uniqueness of the profession.

That the AOA had specialties in preventive medicine and nutrition, realizing that this is the trend of the future.

That every public library had up-to-date information on osteopathic medicine.

That osteopathic hospitals offered OMT to patients as a standard feature.

That the leadership of the profession was open to new and stimulating ideas from a variety of sources.

That DOs as a group stood proud and united, agreeing on at least three (3) fundamental principles.

That DOs were sought out by large employer groups to help keep health care costs down.

That the profession raised its flag to its fullest height, and agreed to help, rather than compete with each other.

That osteopathic physicians realized that the marketplace, more than any other factor, will determine their future and that currently they are a group of people with an undefined product and an under recognized name.

That each DO took action to educate his or her patients about the uniqueness of the profession, starting a grass-roots national awareness program that soon spread to the legislatures and insurance companies.

I awoke suddenly with a start.

Maybe it could be true- become true.

Still. Here and now.

AOHA

A publication of the American Osteopathic Hospital Association

Briefly . . .
Ready Set Focus

On July 8, David Kushner and Joan Cooney met with a group of interns at Tulsa Regional Medical Center. These interns, who will just be starting their internship year, will provide an opportunity to learn what factors shaped their decisions on next year's residency training.

The Board of the Student Osteopathic Medical Association met with Kushner and Cooney in Cleveland on July 18 during AOA's Annual Meeting there. The SOMA board is comprised of second, third and fourth year students. How they learn about and choose residencies will be valuable information. Sessions in other parts of the country are planned for this fall, with a full report of findings to be shared with all AOHA members.

This research activity is being funded by a $10,000 grant from the Foundation of Osteopathic Health Services. AOA and AACOM have also been contacted regarding the project and have offered their suggestions during preparation for the Tulsa session. ▲

HMO Bill Update

Last month AOHA reported on a bill passed into the Florida state legislation addressing osteopathic participation in managed care plans. Complete legislative language has since become available. The bill states that each HMO providing inpatient and outpatient services by allopathic hospitals shall provide as an option to the subscriber similar care by hospitals accredited by the American Osteopathic Association. Congratulations again to Sylvia Urlich of Miami's Westchester Hospital for this success. ▲

Persistence Pays Off

A small but important result of our enhanced legislative program occurred last week. A staff member form the office of Senator Kit Bond (R-MO) called AOHA to discuss the wording for a proposed bill. The bill, entitled the "Families with Children in Need Act," will include incentives for physicians to practice in rural areas. The staff member consulted Catherine Cahill concerning wording for the bill that would clearly include osteopathic physicians. At last word the bill would include a reference to "osteopathic physicians." Although this legislation deals with physicians, not hospitals, we are pleased the Senator's staff thought to contact AOHA during drafting of the bill. ▲

CME OSTEOPATHIC

The Kirksville College of Osteopathic Medicine

will conduct its annual Founder's Day program October 10-12, 1991 in Kirkville, Missouri. The program is elegible for 20 hours of categotry 1-A credit from the AOA.

This program will present practical applications of osteopathic principles in evaluating and treating the spine from the osteopathic perspective. Hands-on osteopathic manipulative treatment sessions will be held daily to emphasize practical techniques for patient care.

For more information contact: Rita Gray Harlow, Continuing Education Coordinator, KCOM, 800 West Jefferson, Kirksville, MO 63501. (816) 626-2232 or (800) 626-5266. ▲

Founders Day Scott Memorial Lecture

KCOM will conduct its annual Founder's Day ceremonies Friday, October 11. J. Scott Heatherington, D.O. will present the Scott Memorial Lecture as part of the day's activities. The Scott Memorial Fund was established in 1963 through the gifts of Jeanette Scott Thurber as a memorial to her parents, John Herbert Brice Scott, D.O. '06, and Katherine Fraser McLeod Scott, D.O., '05. The fund provides an opportunity for Kirksville students to hear an outstanding lecture on osteopathic medicine. ▲

Doctors Hospital Physician Holds National Office

Doctors Hospital Division Chief of Ophthalmology Richard L. Fuller, D.O. has been elected vice chairman of the American Osteopathic Board of Ophthalmology and Otorhinolaryngology (ABOOO). Board certified, Dr. Fuller has been a member of the Doctors Hospital medical staff since 1972. ▲

Clyde B. Jensen Appointed as Interim President

Clyde B. Jensen, Ph.D., Appointed to Serve as Interim President of the University of Health Sciences — College of Osteopathic Medicine

Clyde B. Jensen, Ph.D., has been appointed to serve as interim president of the University of Health Sciences - College of Osteopathic Medicine beginning July 1, 1991. His appointment follows the June 30, 1991, retirement of UHS-COM President Elmer H. Whitten, Ph.D., who has served the university for the past 21 years, the past three as president. ▲

Bedford Physician Presents Paper at National Scientific Seminar

James O. Royder, D.O., Bedford, TX, recently presented a scientific paper at this year's 90th Annual Convention and Scientific Seminar of the American Osteopathic Association (AOA), November 10-14.

Dr. Royder's paper was entitled "Diagnosis and Osteopathic Management of TMJ Dysfunction."

A general practitioner, Dr. Royder is licensed to practice in Texas, Missouri and Ohio. He earned his B.A. degree from the University of Texas, Austin, and his D.O. (Doctor of Osteopathy) degree in 1965 from the Kansas City (MO) College of Osteopathic Medicine. Dr. Royder is a Fellow of the American Academy of Osteopathy (AAO). ▲

AOA Policy Governing Basic Certification

The AOA continuing medical education requirements include the following provision:

Physicians who are board certified or board eligible must earn a minimum of 50 credit hours or more as may be mandated by the board of their primary specialty in each 3-year CME period. These hours may be earned in Category 1 or Category 2. Failure to maintain this requirement will result in loss of certification or board eligibility.

Please note that under current AOA policy, as interpreted by AOA legal counsel, failure to meet the specialty CME requirement would be interpreted as a failure to meet the individual physician's CME requirement. This would result in loss of AOA membership which would in turn result in loss of certification. The cycle for this period ends December 31, 1991, and as of that date all physicians as stated above must have met the 50 hours requirements in their basic certification. ▲

Clues to Claims Fraud

At Emory University Hospital in Atlanta, a survey of 900 patients who filed workers' comp claims found these similarities among claims that turned out to be false:

- The worker often fails to appear for the first doctor's appointment without calling to cancel or reschedule
- The worker is over-dramatic about the pain being felt, yet has trouble finding words to describe the pain
- There is delayed notice and/or improper reporting of the injury
- Friday afternoon injuries are reported on Monday morning
- The first notice of a claim is a letter for an attorney or a hearing notice from a workers' comp agency
- The employee fails to report to work for several days, then reports the injury
- The employee frequently changes doctors, or asks to do so
- The employee is short-term, or has a history of workers' comp claims

(Reprinted from TexasBusiness Today, April 1991.) ▲

96th Annual Convention & Scientific Seminar
AMERICAN OSTEOPATHIC ASSOCIATION
Program Schedule
NEW ORLEANS, LOUISIANA

Theme: Osteopathic Medicine: Defining the Future

Sunday, November 3

10:00 a.m. - 5:00 p.m.	Registration
11:30 a.m. - 2:00 p.m.	Risk Management Seminar (Sponsored by Osteopathic Mutual Insurance Co.)
12:30 p.m. - 4:30 p.m.	Practice Management Seminar (Sponsored by Syntex Laboratories)
12:30 p.m. - 4:30 p.m.	Upjohn Student Seminar
1:00 p.m. - 4:30 p.m.	Exhibits
2:00 p.m. - 5:00 p.m.	AIDS Seminar (Sponsored by AOA Task Force on AIDS; ACGP; and AOCPM)
8:00 p.m. - 10:30 p.m.	Social Event for All Attendees (Sponsored by Lederle Laboratories)

Monday, November 4

7:00 a.m. - 4:30 p.m.	Registration
8:00 a.m. - 9:00 a.m.	OPENING SESSION - KEYNOTE SPEAKER
9:00 a.m. - 4:30 p.m.	Exhibits (Closed 1:15 p.m. - 2:30 p.m.)
9:00 a.m. - 1:00 p.m.	Didactic Sessions
1:15 p.m. - 3:00 p.m.	ALUMNI LUNCHEONS
3:00 p.m. - 4:30 p.m.	Didactic Sessions
5:30 p.m. - 7:00 p.m.	Reception (Sponsored by ICI Pharma, Division of ICI Americas)
Evening	Affiliated Organizations and Fraternity Functions
10:00 p.m.	Chocolate Fantasy (Sponsored by Syntex Laboratories)

Tuesday, November 5

6:00 a.m. - 8:00 a.m.	8th Annual Cardio Fun Run (Sponsored by Rorer Pharmaceuticals)
7:00 a.m. - 8:00 a.m.	The "Better Health" Breakfast (Sponsored by Fleishmann's)
8:00 a.m. - 4:30 p.m.	Exhibits
8:30 a.m. - 12:00 Noon	Didactic Sessions
12:00 Noon - 1:30 p.m.	Lunch Break
1:30 p.m. - 4:30 p.m.	Didactic Sessions
6:30 p.m. - 8:00 p.m.	Reception (Sponsored by Eli Lilly & Co.)
8:00 p.m. - 10:30 p.m.	AOA President's Banquet

Wednesday, November 6

8:00 a.m. - 1:00 p.m.	Exhibits
8:30 a.m. - 12:00 Noon	Didactic Sessions
12:00 Noon - 1:30 p.m.	Lunch Break
1:30 p.m. - 4:30 p.m.	Didactic Sessions
Evening	Affiliated Organizations Functions

Thursday, November 7

8:00 a.m. - 1:00 p.m.	Joint Session - All Groups Participating (Sponsored by the Upjohn Company)
1:00 p.m. - 2:30 p.m.	Luncheon (Sponsored by the Upjohn Company)

Registration, exhibits and didactic sessions will be held at the New Orleans Convention Center. The official hotels are the Hilton Riverside & Towers, Holiday Inn Crowne Plaza, Hyatt Regency, and Sheraton.

CONTINUING MEDICAL EDUCATION CREDITS (CME - CATEGORY 1A)

TOTAL: 26 HOURS

NOTE: Three (3) additional CME credits will be allowed for visiting commercial exhibits and one (1) additional CME credit for visiting scientific exhibits.

American Academy of Osteopathy

1991 CONVENTION PROGRAM SCHEDULE

New Orleans, Louisiana

Osteopathic Concepts in Female Health Care

Monday, November 4

8:30 am- 9:00 am	*Introduction and Opening Remarks* Gilbert S. Bucholz, DO, AOA President J. Scott Heatherington, DO, AAO President Melicien A. Tettambel, DO, Program Chairperson
9:00 am- 9:50 am	*Women in Osteopathic Medicine I — Historical Perspective* — Georgia Walters
10:00 am-10:50 am	*Women in Osteopathic Medicine II — Current Perspective* — Helen H. Baker, PhD
11:00 am-11:50 am	*Female Psyche and Soma* — Johanna K. Leuchter, DO
12:00 pm-12:50 pm	*"Osteopathic" Approach to Difficult Colleagues and Patients* — Sharon E. Rohrbach, DO
12:50 pm- 3:00 pm	Lunch Break
3:00 pm- 5:00 pm	*Building Bridges to Leadership* — Laurie B. Jones

Tuesday, November 5

8:00 am- 8:50 am	*Recognizing Addiction and Abuse* — Roberta L. Fennig, DO
9:00 am- 9:50 am	*Sexually Transmitted Diseases — Women at Risk* — Mary C. MacGregor, DO
10:00 am-10:50 am	*Women as Victims in the Home, Workplace, Society* — B. Gene Chilton, DO
11:00 am-11:50 am	*Women, Diet and Exercise* — Karen Gajda, DO
11:50 am- 1:00 pm	Lunch Break
1:00 pm- 1:50 pm	*Dermatologic Manifestations of Systemic Diseases in Females* — Colleen A. Keegan, DO
2:00 pm- 2:50 pm	*Diagnosis and Management of Breast Disease — Update* — Constance Cashen, DO
3:00 pm- 3:50 pm	*Chronic Yeast Infection — Is It Real?* — Laurey R. Hanselmann, DO
4:00 pm- 4:50 pm	*Geriatric Gynecology* — Sandra S. Retzky, DO

Wednesday, November 6

(Joint program with the American Osteopathic Academy of Sclerotherapy)

8:00 am- 8:50 am	*Osteopathic Approach to PMS* — Ann L. Habenicht, DO
9:00 am- 9:50 am	*Osteopathic Approach to Osteoporosis* — Isabelle A. Chapello, DO, FAAO
10:00 am-10:50 am	*Diagnosis of Unstable Low Back* — Joan M. Resk, DO
11:00 am-11:50 am	*X-ray Exam of the Low Back* — Joan L. Moore, DO
12:30 pm- 3:00 pm	AAO Membership Luncheon T.L. Northup Lecture — Robert E. Kappler, DO, FAAO
3:00 pm- 5:00 pm	**Workshops: Low Back Pain Syndromes — Herniated Disc, Spondylolisthesis**
3:00 pm- 3:30 pm and 4:00 pm- 4:30 pm	*Osteopathic Management of Low Back Pain* — Isabelle A. Chapello, DO, FAAO and Ann L. Habenicht, DO
3:30 pm- 4:00 pm and 4:30 pm- 5:00 pm	*Sclerotherapy of Low Back Pain* — Andrew L. Kulik, DO

Additional Meeting Information:

- AOBSPOMM examinations will begin at 8:00 am on Sunday, November 3 in the Oak Alley Room of the New Orleans Hilton.
- The Academy Board of Trustees will meet at 1:30 pm on Saturday, November 2 and at 8:00 am on Sunday, November 3.
- The Cranial Academy Board of Trustees will meet at 12 noon on Saturday, November 2.

Don't miss this one!

American Academy of Osteopathy

OMT UPDATE

"Application of Osteopathic Concepts in Clinical Medicine"

and

"Preparation for OMM Boards"

October 3-6, 1991

Walt Disney World

Orlando, Florida

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