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JOURNAL
A Publication of the American Academy of Osteopathy
VOLUME 3 NUMBER 3 FALL 1993

Osteopathy in the World of Medicine

See page 9

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THE AAO JOURNAL
A Publication of the American Academy of Osteopathy

The mission of the American Academy of Osteopathy is to teach, explore, advocate, and advance the study and application of the science and art of total health care management, emphasizing palpatory diagnosis and osteopathic manipulative treatment.

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From the Editor

OMT — Finding the Time

One of my friends and colleagues is an osteopathic family physician who is also noted for his considerable skill in performing osteopathic manipulative treatment for a variety of conditions. One day not long ago we found ourselves talking about osteopathic manipulation, wondering why some DOs don't do very much of it. "Well," he said, "I'd like to do even more manipulation than I already do, but I just don't have the time." My first inclination was to agree with my friend. We all know how busy a practice can be, and sometimes we feel there is just not enough time to do all the things we would like to do for our patients.

But later on that day, after we had parted, I had another thought altogether. This idea of not having enough time to do OMT is an excuse I've heard more than once from various osteopathic physicians. Well, baloney! I always seem to have enough time to see patients, handle their complaints, and do some OMT with them as well. It doesn't seem to take me any more or less time than a typical office visit for most patients. So I wondered, how can anyone not have time to do OMT? It seems like there should always be enough time, within the course of a routine office visit, to discern the patient's problem, decide on a course of action, and do some appropriate OMT as well.

There is scientific data to support this idea. In his book, *Clinical Epidemiology: A Basic Science for Clinicians* (p. 16), Sackett relates the following information: "When Howard Barrows, Geoffrey Norman, Victor Neufeld, and John Feightner videotaped random samples of family physicians and internists working up programmed patients with pericarditis, duodenal ulcer, peripheral neuropathy or multiple sclerosis, they documented that the first hypothesis was generated, on average, 28 seconds after hearing the chief complaint (varying from 11 seconds for the multiple sclerosis patient to 55 seconds for the peripheral neuropathy patient). The correct hypotheses... were generated an average of six minutes into these half-hour work-ups (in less than a minute for the multiple sclerosis patient and less than 90 seconds for the duodenal ulcer patient), and an average of 5.5 hypotheses were generated for each case."

I found this information incredibly interesting. A physician needs half a minute to start formulating an hypothesis about what's going on with a given patient, and only six minutes, on average, to come up with the correct diagnosis. Now let's suppose you're seeing patients at 15 minute intervals as a lot of family physicians do for most routine office visits. If you only need six minutes or less to figure out what's wrong with a patient and what you're going to do about it, what are you going to do with the other ten minutes? My suggestion is that while you are discussing your findings with the patient and giving advice, you could also be doing some OMT appropriate for this particular patient's problem. It doesn't have to be a fancy, complex treatment — just a brief local treatment can do wonders for your patient in terms of helping him or her to feel better, recover faster and stay well longer.

So the next time you're wondering how you could be doing more OMT with your patients, give this idea a try. I think you'll find that it's not too difficult to add even more of the osteopathic dimension to your practice. OMT — you don't have to find the time; just make use of the time you've already got. ❑

A few random thoughts to share with this year's graduating osteopathic medical students:

The Graduates

In flowing robes
march proudly in a line
step upon the stage and receive
the parchment that says
you are ready;
ready for the internship, the residency;
ready to care for those you adore
even more than their illnesses.

Graduates
in flowing robes
march proudly in a line;
step upon the stage and receive
the parchment that says
you are ready;
ready to care for those you adore;
some of whom at times
will bleed in your hands like saints.

AAO Annual Convocation

March 23-26, 1994
The Broadmoor Hotel
Colorado Springs

INSTRUCTIONS FOR AUTHORS

The American Academy of Osteopathy (AAO) Journal is intended as a forum for disseminating information on the science and art of osteopathic manipulative medicine. It is directed toward osteopathic physicians, students, interns and residents, and particularly toward those physicians with a special interest in osteopathic manipulative treatment.

The AAO Journal welcomes contributions in the following categories:

Original Contributions
Clinical or applied research, or basic science research related to clinical practice.

Case Reports
Unusual clinical presentations, newly recognized situations, or rarely reported features.

Clinical Practice
Articles about practical applications for general practitioners or specialists.

Special Communications
Items related to the art of practice, such as poems, essays and stories.

Letters to the Editor
Comments on articles published in The AAO Journal or new information on clinical topics.

Professional News
News of promotions, awards, appointments and other similar professional activities.

Book Reviews
Reviews of publications related to osteopathic manipulative medicine and to manipulative medicine in general.

Note: Contributions are accepted from members of the AOA, faculty members in osteopathic medical colleges, osteopathic residents and interns and students of osteopathic colleges. Contributions by others are accepted on an individual basis.

Submission
Submit all papers to Raymond J. Hruby, DO, FAAO, Editor-in-Chief, University of New England, 11 Hills Beach Road, Biddeford, ME 04005.

Editorial Review
Papers submitted to The AAO Journal may be submitted for review by the Editorial Board. Notification of acceptance or rejection usually is given within three months after receipt of the paper; publication follows as soon as possible thereafter, depending upon the backlog of papers. Some papers may be rejected because of duplication of subject matter or the need to establish priorities on the use of limited space.

Requirements for manuscript submission:

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1. Type all text, references and tabular material using upper and lower case, double-spaced with one-inch margins. Number all pages consecutively.
2. Submit original plus one copy. Please retain one copy for your files.
3. Check that all references, tables and figures are cited in the text and in numerical order.
4. Include a cover letter that gives the author's full name and address, telephone number, institution from which work initiated, and academic title or position.

Computer Disks
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1. Be sure that illustrations submitted are clearly labeled.
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2. For journals, include the names of all authors, complete title of the article, name of the journal, volume number, date and inclusive page numbers. For books, include the name(s) of the editor(s), name and location of publisher and year of publication. Give page numbers for exact quotations.

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All accepted articles are subject to copy editing. Authors are responsible for all statements, including changes made by the manuscript editor. No material may be reprinted from The AAO Journal without the written permission of the editor and the author(s). ❑

To The Editor

To the Editor,

Some time ago in the Journal of the American Osteopathic Association, an article was authored by Drs. Kasovac and Jones entitled *"Integrate Osteopathic Principles and Practices in Postgraduate Medical Education — Now!"* (Vol. 93, No. 1, Pg. 118-125, 1993)

I was elated to see that these two individuals had the courage to write such a timely and enlightening article about the importance of OMT and the osteopathic holistic approach in primary care teaching programs.

I am not alone when it comes to the fact that today few "role models" exist for osteopathic medical students, interns, and residents, a group I was part of only a few years ago. Now that I am in the private practice of Family Medicine, I can see the positively rich rewards of learning how to integrate my OMT skills into everyday situations. I am intimately involved with training students and residents as well as introducing many people who are seeking medicine as a career and interested in what a DO does differently than an MD or a DC.

DOs are "missing the boat," so to say, if they don't wake up and realize that their holistic and hands-on training is a tremendous advantage in today's medical marketplace, regardless of the Clinton decisions. Instead, it seems the "experts" in manipulation and holistic approaches include chiropractors, physical therapists, massage therapists, acupuncturists, and various other "alternative" practitioners, none of whom have formal medical training as do DOs.

Indeed, many DOs cringe at the thought of being compared to "alternative" medical practitioners. Although I understand their concern, it really should be construed as a complementary descriptive aspect of the DO degree. There hasn't been a day that goes by in my practice that I don't meet a new patient who is thrilled that they found a DO who uses his hands as well as a holistic approach to care. I am amazed that intelligent, well-informed, and yes, even well-to-do people with insurance are actually seeking this type of care and attitude. Even Medicare reimburses us 100 percent for OMT when it is done both in the outpatient and inpatient settings. I only wish that critics and cynics of DOs and OMT could see that aspect.

One of my main criticisms is the continuation of our outdated osteopathic nomenclature. It is not only confusing, but serves to make it difficult to communicate with our peers in the *entire* medical and lay population. Only a fraction of DOs even understand and utilize it, not to mention the difficulty in teaching the concepts to students. I personally have had to modify it so that my peers, *both* MD and DO, as well as the legal, insurance, and other lay populations, may understand my findings, diagnosis, rationale, and treatment plans.

OMT and its practicality should be pointed out whenever possible and its role in both the office and hospital settings stressed. All of these principles are and have been integrated into my practice, which serves as an official OMT rotation for a DO internship/PGY-1 residency program in New Jersey. In fact, during my residency in Family Practice, I generated so much enthusiasm in re-introducing osteopathic principles into the out/inpatient setting that both I and my associate were offered the opportunity to extend this enthusiasm into teaching OMT with a clinical emphasis in our office. It now has caught the attention of our MD colleagues who "reward" us with both open-mindedness, interest, and a new-found referral source from which we have "created" a nice subspecialty, if you will, because we happen to be among the few DOs in the area who actively use our hands in many facets of primary care. Many osteopathic students routinely call to spend a week in our office to gain whatever new perspective or "slant" on the importance and advantage of utilizing one's hands to help alleviate many commonly seen outpatient problems.

We also practice applicable OMT techniques, preferably soft-tissue in nature, in the hospital as well. This is reflected in my history and physical, admit note, daily progress notes, and discharge summary just as all other pertinent medical documentation. All of this is done in a predominantly allopathic suburban private hospital which several decades ago refused DOs practice rights. Although there still remains a subtle traditional prejudice as elsewhere, many DOs are welcomed in all departments, thanks to earlier efforts of DOs like my associate and others who risked their professional reputations and slanderous publicity in those days so that their successors could practice without discrimination.

Our profession is so allopathically oriented and far from the emphasis on primary care that it is no wonder that our students seek non-osteopathic training programs. I was fortunate. I had a role models. It's time to find more DOs who stand up and display their DO degree without concern for public or professional misconceptions and use OMT and/or the osteopathic holistic philosophy in some way in their practices. Our literature and conventions *must* display a sense of renewed pride in our uniqueness and advantages, especially in primary care and sports medicine. Right now, the lack of emphasis on OMT in meetings and in our literature is abysmal; it should play a major role.

There could not be a better time for DOs to reveal medicine's best kept secret, OMT and the osteopathic holistic philosophy. It's an American original, begun by an MD, and is both successful and extremely cost effective. Thanks to the persistence of pioneers like Howard Levine, DO and his OMT research studies, the AAO, and the select DOs who enjoy using their hands to complement their medical skills, osteopathic medicine can remain distinct and even become a newly discovered medical entity for the rest of the country to look up to.

Let's get rid of the rampant apathy that pervades our profession. Let's turn the current public outcry for alternative medicine and primary care into an *advantage*. Remember, OMT and our holistic training is an *asset*, not a liability.

I only hope this stimulates dialogue among my colleagues. Our profession is doomed to stagnation and eventual extinction unless our *differences* not similarities in medicine are emphasized.

David S. Abend, DO
Emerson, NJ

Message from the Executive Director

Stephen J. Noone, CAE

** The 1993 AOA House of Delegates approved a resolution proposed by the New York State Osteopathic Medical Society (NYSOMS) calling for the AOA to pursue aggressively the adoption of a national policy on reimbursement for both the evaluation and management service as well as osteopathic manipulative treatment. AAO member **Wayne Harbinger**, as NYSOMS' executive director, advocated the adoption of the measure before the Reference Committee on Public Affairs. The House also approved the NYSOMS' statement which DOs can use in their battles with third party payors for payment of both E&M service and OMT:

> "Quality care guidelines in osteopathic medicine require that I perform a history and physical examination or an interim history of the chief complaint and circumstances since previous treatment. In addition, I must consider results of any other entities such as rest, ice, heat, exercise, daily activities, medications, etc., and a complete musculoskeletal examination of related areas of the body, including other evaluations pertinent to differential diagnosis before performance of osteopathic manipulative treatment (OMT).
>
> This evaluation and management service is a significant, seperately identifiable service. OMT is specific to the physical findings of the same day. Return visits are made for an interim history and examination service and OMT is then rendered for the specific treatment based on that examination. These evaluation and management services and manipulative treatments are 'physician and surgeon only' procedures to meet quality care standards."

Please make a copy of this statement and use it routinely when filing your claims for reimbursement of E&M services and OMT on the same day of service.

** At its July meeting, the AAO Board of Trustees voted to welcome as ASSOCIATE MEMBERS foreign DOs who are members of a governmentally-recognized registry within their own countries. They took this action since foreign osteopaths are permitted to attend AAO educational programs by virtue of a Board of Governors policy adopted in 1991 and since the AAO Bylaws authorize the Board of Trustees to grant ASSOCIATE MEMBERSHIP to "professionals as determined by the Board of Trustees." However, these prospective members must meet all the requirements for Associate members as specified in the AAO Bylaws. The formal action was:

> "Resolved that the AAO Board of Trustees invite the written application for AAO ASSOCIATE MEMBERSHIP from any foreign D.O. who is a member of a governmentally-recognized registry within his/her own country; and be it further
>
> Resolved that such applicant fulfill all other requirements for ASSOCIATE MEMBERSHIP as established by the AAO, *including sponsorship by one active AAO member in good standing and unanimous approval by the Board of Trustees."*

I do not anticipate any large number of applicants for Associate membership as a result of this Board action. However, the vote will enable the handful of Supporters and foreign osteopaths who attend Convocation to make application for AAO membership.

** Education Chairman **Boyd Buser** welcomed nine of the 12 committee members to a meeting at the AAO headquarters last week. Significant actions of the Committee included the following:

++ Program Chairman **William Kirmes** will conduct a brief survey of AAO members regarding the Faculty Development Conference in the October issue of *The AAO Newsletter*.

++ In a discussion facilitated by **Carlisle Holland**, committee members developed a rough proposal on the training of non-DOs in osteopathic manipulative medicine. This project is in response to a charge given to the Committee by the Board of Trustees last March and relates to the AAO Resolution approved by the AOA's House of Delegates last month.

++ The group considered alternative sites for the 1995 AAO Convocation, scheduled previously for the Hyatt Regency San Antonio, which can no longer accommodate the Academy's meeting space needs. The Committee will make a recommendation to the Board of Trustees for action in October.

continued on page 21

Message From the President

Herbert A. Yates, DO, FAAO

Osteopathy has entered its Second Century with many proud accomplishments. Osteopathic physicians have cared for ordinary people, presidents, the powerful and the poor. We have cared for urban and rural — and everything in between. We've relieved the ills of more than our share. Today osteopathic physicians are less than six percent of the nation's doctors, yet we care for 10 percent of the population, 15 percent of Medicare, 15 percent of rural (under 10,000 population) and over 20 percent of Medicaid. We are the best trained physicians in the world. More than that — we are the only fully trained profession of physicians in this country — we are trained in all aspects of Standard Medical Practices from day one of our osteopathic medical training. We excel. Like Avis, we try harder. We are different. We are more — humane, more holistic, more caring in our general approach to a person who comes to us with his or her problems. We tend to treat people not just diseases. We are what the country, including Hillary Rodham Clinton is looking for — a balanced health profession that is primary care oriented, hands on, caring — fully qualified and capable physicians. We are the bridge between traditional and alternative health care yet we are the best kept secret in this country.

We have a century of service. We have more than our theoretical share of the market. We are rapidly growing. We, osteopathic physicians are proud, confident, focused on rendering the highest quality of osteopathic care. We are taking the tenets and principles first enunciated by A.T. Still and we now apply those tenets, along with the additional knowledge and skills we have learned. We apply these to the betterment of our patients and society.

Now that we are sure and proud, what do we do? Among other things; we must all become more empowered and involved. The old autocratic hierarchies are crumbling throughout our society. Leadership styles are shifting to participative and the decision making power is becoming distributed to the grass roots. We must get more involved; with the AAO with our local and state osteopathic medical groups — with the AOA and its political and service endeavors, with local, state and national politics.

I can hear the groans from many of my friends. They say, "Me get political? You have to be kidding! I do not want to be involved politically, and if I did want to get involved, I do not know how" or "I've tried but I just don't like politics" or some other reason.

To tell the truth, I don't like politics either. However, I have not always liked the directions my local, state national organizations have taken. I have watched power hungry politicians make decisions that gave themselves more power and did not help us or our profession. I don't like that! What is the solution? If you want something done right do it yourself — or at least help do it. I've watched as throughout the world the power bases of power hungry fools crumble as the "Silent Majority" of ethical, caring, giving non-politicians became involved. Gideon took a few dozen men and attacked an army of thousands; they won. The American colonists defeated the greatest military power on earth, the British Empire. The small shepherd boy, David, toppled the great armored giant, Goliath. He did this by seeing beyond an enemy that was too large to defeat. He saw a target too large to miss. He made a difference. You can make a difference — maybe today, maybe tomorrow or the next day or, it may take years to evolve our organizations to be what we want them to be. However, if we don't start now we cannot correct the inertia and if we don't — if you don't — who will? I am looking forward to watching each of us get more involved and help make a difference.❑

OMT Update

February 12-13, 1994

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Osteopathic Medicine

by James A. Keller, DO

[Editor's Note: James A. Keller, DO, is a 1932 graduate of KCOM presently living in Kirksville, MO. Dr. Keller is retired and holds an Honorary Life Membership in the AAO.]

This paper is written in an effort to clarify the position of osteopathic medicine in the world of MEDICINE. Let's go first to Dorland's Medical Dictionary of the 23rd edition where we read the definition of medicine; (1) any drugs or remedy (2) the art or science of healing diseases; especially the healing of disease by the administration of internal remedies.

Further down the column and still under MEDICINE we find the definition of holistic medicine - a system of medicine which considers man as a integrated whole or as a functioning unit.

Next is physical medicine; the employment of physical means in diagnosis and treatment of disease - it includes the use of heat, cold, water, light, electricity, manipulation, massage, exercises and mechanical devices.

There are other definitions under medicine but they do not link as closely with our discussion.

Now under osteopathy the first definition relates to the word itself - any disease of the bone.

Secondly, a system of therapy founded by Andrew Taylor Still and based on the theory that the body is capable of making its own remedies against disease and other toxic conditions when it is in normal structural relationships and has favorable environmental conditions and adequate nutrition. It utilizes generally accepted physical, medical, and surgical methods of diagnosis and therapy while placing chief emphasis on the importance of normal body mechanics and manipulative methods of detecting and correcting faulty structure.

Now a few comments about these definitions.

The definition of medicine we all know does not encompass all of the problem of MEDICINE. There is no question that holistic medicine is pointing our thinking in the right di rection but none of the definitions except the definition of osteopathy, as defined by Dr. Still, come anywhere close . There is no discipline that takes full advantage of all aspects of the "functioning unit" in maintaining man at his highest level or in bringing him out of illness or deficiency.

Osteopathic Medicine uses and embraces a greater number of therapeutic measures

Physical medicine with heat, massage, manipulation, etc. deals with only a limited field of man's maladies.

Preventive medicine deals with only a limited number of measures that prevent disease.

Osteopathic medicine, according to Dorland's definition, uses and embraces a greater number of therapeutic measures than any of the above defined systems.

However, there are few DOs that take full advantage of what they know or appear to know about the maintenance of man's health or in assisting the body to overcome disease. It may be said that manipulation, for instance, is used by other disciplines but the manipulation isn't used or directed toward the normalization of the somatovisceral or the viscerosomatic reflexes as an osteopathic physician can. The osteopathic physician recognizes the influence of structural imbalance, occupational stress, injury, habit, etc. in the production of somatic dysfunction, to say nothing about the influence of the viscerosomatic reflex, in producing diminished body ability to prevent disease in the medical, surgical, or obstetrical fields.

So as we look at the definitions the osteopathic physician comes closest to being what one may point to as a complete physician or one practicing holistic medicine. Without the osteopathic manipulation even the DO cannot claim to be holistic.

To carry this thinking to its conclusion we are forced to admit that without the use of OMT no treatment

regimen may be considered as effective as it can be in any field of practice. The somatovisceral and the viscerosomatic reflexes must be, in so far as possible, eliminated before the other entities of any treatment regimen can be completely effective.

Personally I see little difference in the necessity of a manipulative specialist knowing the chemistry, etc. of prescriptions he may write and the internist who uses medicine as his specialized service and the necessity of his knowing the fundamentals of

... osteopathic lesions should be removed as soon as practical ...

the manipulation he should use. They both have the DO degree, and the only time they need to refer a patient is in the case in which a manipulation is needed that requires a residency to be proficient in its application or in the case of the necessity in use of a treatment regimen of medicine needed that requires residency to prescribe.

There is another consideration and I might say a focus of much argument: The time factor in the use of OMT. Some, they say, don't have time to give OMT. I don't care what techniques a manipulative specialist may use. He/she gets cases where a wide range of technique may enhance his/her percentage of recovery and success. However, the GP and the specialist using OMT as part of a treatment regimen needs only a few techniques for each somatic dysfunction that he/she can use quickly and accurately on demand. I've given treatments in 2 1/2 minutes and don't think I'd miss 10 minutes much as an average. I saw one man give 80 OMT per day between 8:00 and 12:00 and 1:00 and 5:00. He charged more than most of us and was busy daily. The public comes to the place where they get results and their money's worth. Every six minutes he'd have another patient.

After a physician is familiar with the offending somatic dysfunction, it shouldn't take him long to handle it. Dr. Charlie Still told me once when asked how long it took them in those days to give a treatment, he said "Oh, hell, Jim, if they come in with a rib lesion, back them up against a wall and fix it." I'm for it.

Any osteopathic lesion associated neurologically or structurally with any organ expressing a problem by pain or malfunction (diminished or hyperactivity) should be *removed before any heroic program is made permanent*. Or if any emergency measures were necessary, the osteopathic lesions should be removed as soon as practical to assist in reducing aftereffects of emergency measures. Any osteopathic lesion of the viscerosomatic nature that persists after adequate effort to eliminate it demands a very careful re-evaluation of the associated organ. I do not recall of finding a disorder without viscerosomatic evidence of its presence unless the diagnosis of historical elements were in error. Don't try to get it all done in one treatment - it didn't get that way in 15 minutes unless you are dealing with acute entities. It may take many months before dismissal is in order or it may be necessary to set up a lifetime program. A program of preventive care including *periodic regular* manipulative care for the infants and children up to the age of 20 is very effective (also in the old age group).

The wider the range of methods of application, the wider the range of entity that may be manipulated successfully with benefit to the patient.

There are only three contraindications for manipulation:

1) Don't treat anyone against his or her will.

2) Don't manipulate a broken bone or torn tissue.

3) Don't manipulate tissue affected by malignancy, inflammation, induration or hemorrhage.

The last two (2-3) refer *only* to the tissue affected but *not* the ill person in other areas. To illustrate these facts the following experiences have been chosen from fifty years of manipulation directed toward the viscerosomatic and somatovisceral reflexes as they have been associated with a wide range of disease. These experiences have sold me hook, line, and sinker on the statement made by Dr. Still that Osteopathy was brought forward "to improve medicine, surgery, and obstetrics."

Dosage frequency, intensity of each treatment, how many and for what period of time the OMTs are to be given will be discussed.

Manipulative Successes

The following is an effort at verifying the statement of Dr. A.T. Still in which he said that the purpose of osteopathy was to improve the practice of medicine, surgery and obstetrics. These case reports will not be reported fully as one would want for one's medical records in the office but rather to record the main effect of manipulative care.

One of the first of these cases was a male who came complaining of pain and stiffness of the cervical and contiguous segments of the thoracic area. History noted that he had just been to

a doctor who had examined his eyes and prescribed glasses. After three or four OMT he told me that his new glasses had come in but he couldn't use them. The doctor had rechecked the prescription and the glasses were made with the correct prescription. Then he asked what had been done between the day of his first visit when he examined his eyes and the present

There is no endocrine disease regimen which is adequate without OMT

time—two weeks later. The patient told of having OMT to which the doctor suggested he finish getting OMT and return for re-evaluation. About a month later the re-examination showed that the patient needed only about half of the previous correction.

To me, the osteopathic eye physician should check for and eliminate any somatic dysfunction of this area before giving the examination for glasses to any patient. This might eliminate the necessity for glasses in some cases and a more accurate prescription in others.

The ear, nose and throat specialist runs into many sinus problems. One is that of congestion and lack of drainage of the nasal sinuses. I wish I had counted the times I have been treating the cervical area for whatever problem the patient has said, "Hey, get me a tissue or something to spit into." He would proceed to empty the nasal area of large quantities of mucopurulent material. It would seem that causing the body to care for itself is far ahead of the situation where a medication alone is used to drain the sinuses. At least the cooperation of a normally functioning body would give higher percent of success. It takes only 3-5 minutes to give OMT to the neck and head.

More permanent results are obtained with the effects of somatic dysfunction eliminated. The frequency of OMT in this area will depend on the patient, the formation of the septum, general health, adequate diet, occupation, chronicity of somatic dysfunction, etc.

Old injuries are a bane of many physicians' existence. There are many in our society and along with tendencies toward arthritis, gout, age, etc., these are persistent in appearing in the office for care. There is no treatment regimen adequate that does not have in it the OMT. Dosage here will be dependent on many factors known by the physician and can be determined by an adequate history and physical. It should be gauged by palpation and the frequency with which palpation show stiffness and tenseness. I know this may seem a trial and error program but one must have these cases in a list that is reviewed every 60 to 90 days. Ask the patient to let you put him on a list to he called regularly. One patient I dismissed only after 18 months.

One patient came with a complaint of stiffness and discomfort of the mid-thoracic area . After three or four treatments, the patient came complaining that after the last OMT he felt weak, broke out in sweat, and thought he'd faint. Apparently I'd missed a very important physical entity. The patient was a diabetic. He was told to go to his physician for blood sugar immediately. His physician reduced the insulin to 15 units daily instead of thirty.

There is no endocrine disease regimen which is adequate without OMT. Without question, a viscerosomatic lesion is present in these cases and this patient should be put on the programmed calling list.

A newborn came to my attention. The nurses were taking 30 minutes to get 2-3 ounces of food into this infant who had been born with difficulty. On examination it was found that the occipital condyles, through which the motor nerves to the tongue must go, were asymmetrically placed. It took perhaps two minutes to re-align them. The next time the nurse fed the child it took less than 15 minutes to get 3-5 ounces of food into his stomach.

A very troublesome group of people are those with gastric or duodenal ulcers. Many of these folks have pain and discomfort in spite of the ordinary medication. Many of these do not heal easily and are prone to recur. Viscerosomatic reflexes always create somatic dysfunction in the area of T4-8. These are usually chronic because of the nature of the disease. It will take 3-5 minutes of OMT on a

It took perhaps two minutes to re-align the occipital condyles

daily or every other day basis to mo bilize these joints. To maintain mobilization the patient may be seen once per week, every two weeks, then once per month or some such program that does not permit somatic dysfunction to re-establish itself. It is comes loose easily on one visit, lengthen the interim time to see how far the visits

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Letter to A.T. Still

Dear Doctor Still,

It occurs to me that we don't seem to understand nearly as much as we should about proper diaphragm function relative to the overall health of the body. We know, of course, that we have to breathe to stay alive, and we need our diaphragm to breathe. But what kinds of effects, both gross and subtle, does somatic dysfunction of the diaphragm have on the whole body? It seems we could spend a lifetime studying the diaphragm alone in this regard. You certainly placed a strong emphasis on the diaphragm and its functions. It was so important to you that you devoted an entire section (Chapter VII) to it in your book, *Philosophy of Osteopathy*. In fact, you said "the diaphragm is possibly the least understood as being the cause of more diseases, when its supports are not all in line and normal position, than any other part of the body." You especially noted that all parts if the body have either a direct or indirect connection to the diaphragm. That may sound a little strange as first, but if one thinks about it a little, that statement seems more and more true. Not only does it play an important role in respiration, but it also functions in keeping blood and fluids moving to all parts of the body. If we really think about the diaphragm, the osteopathic concept that 'motion is life' is strikingly demonstrated. As you said, "I am strongly impressed that the diaphragm has much to do in keeping all the machinery and organs of life in a healthy condition..." It's hard to think of the diaphragm without eventually thinking of the whole body. Just more of your wisdom in action.

Your ongoing student,
Raymond J. Hruby, DO, FAAO ❑

What is a Poor Osteopath to do?

by Daniel M. Allen, DO

You grow up on the farm thinking that life is good. Life is a gift from God. You watch the life cycle in all its beauty and intricate completeness. You watch things fail, weaken, break and become repaired. You injure yourself and marvel at the complete, spontaneous resolution of pain; over and over again. You watch your body change and develop, strengthen and mature. Your family interacts on a natural level, from instinct to developed patterns of flow.

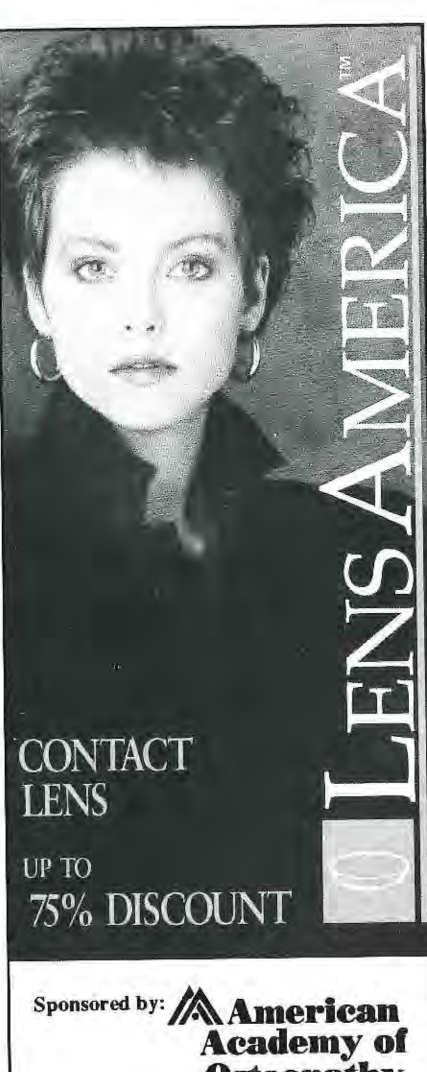
You travel life's road watching the attitudes of "the normal" traverse further and further from your own understanding of the natural world and natural laws. The power and security of perpetual balance and harmony seem to be lost.

The simple idea of osteopathy. Man is good. Man is of God, the universal life force. Man is composed of natural components and follows natural laws.

Nature conserves physical material, conserves construction costs through effective design. Design develops in response to need. Design is thermodynamically inevitable in response to the summation of the total forces of the universe acting on a single time and space. No aspect of the human body is without purpose, without function. Everything exists for reason. Yes, even the vermiform appendix. Nothing in nature can be disregarded or taken for granted. All has a purpose of being. Osteopathy was developed in response to the failure of modern western thought to conform to the laws of nature. The knowledge of true understanding must evolve slowly over time.

Mindless protocol has no place in the thoughts of an osteopath. Each event, each situation acquires its own unique nuance. To ignore this is to ignore the true essence of life. We still have a long way to go. ❑

[Editor's note: Dr. Allen is a resident in the Department of OMM at Kirksville College of Osteopathic Medicine.]



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From the AOBSPOMM Files

AAO Case History

by Lillian Somner, DO

Mr. G.F. presented to my office on a Wednesday morning with the chief complaint of severe pain that began in the top portion of his neck and radiated into the scalp behind his left ear. The pain was accompanied by numbness and pain in the entire face, both sides, but the left was more severe than the right. On initial quick exam the patient appeared in moderate distress due to the intensity of the pain which was paroxysmal in nature. The pain would cause his head to flex on the neck and cause him to wince with his left eye. His left eye was irritated, red and tearing. He could not move his mouth fully on the left side but denied difficulty swallowing or eating. Due to other patient commitments I was unable to examine or treat him more fully at that moment so I gave him oral Toradol and had him return in a few hours when I could give him my undivided attention.

On return to my office his history was as follows: Mr. G.F. is a forty year old male who was in good health until three weeks previously when he developed a sore throat which was diagnosed as Streptococcal pharyngitis and treated with a ten day course of penicillin. The pharyngitis was accompanied by bouts of fever as high as 103 degrees. He still had symptoms at the end of ten days and a course of amoxicillin was given for another ten days. He also developed an infection in a psoriatic patch behind his left ear which resolved with the amoxicillin. The day immediately following the completion of the amoxicillin he began to notice pain in his teeth. The pain in the teeth spread to a feeling of numbness in the entire face and a pain in the neck which radiated up the side of his head, behind his left ear to the temple. He first noticed these symptoms on a Thursday. By Sunday the symptoms seemed to resolve somewhat and he was able to play a game of tennis but felt that the exertion increased his level of pain. The following Monday he consulted a neurologist in Baltimore where he attended physical therapy school. The neurologist diagnosed greater occipital neuritis and, coincidentally and unrelated, a mild trigeminal neuralgia. Indocin was prescribed and the patient was given the instructions that the neuritis would clear within ten days but to call if the pain worsened. No imaging studies were ordered at that time. He returned to the Washington area to be with his family. Two days later he called me due to severe facial pain as described above.

Physical exam revealed a man in mild distress. The Toradol had dramatically improved his symptoms. Neurological exam revealed full sensation of the face to pin prick and two point discrimination; there was full function of all the cranial nerves. The weakness witnessed early in the perioral muscles was most likely due to guarding from the pain and had resolved completely. He had restricted passive rotation of the cervical spine. Structural exam revealed severe somatic dysfunction from OA to C3 with marked restriction in rotation. Cranial assessment revealed a severe compression of the SBS and no other SBS strain pattern. I also felt a strong pull from the cranial membranes; it felt as though the neck were pulling the head into the cervical spine with great force. The occiput did not move.

Treatment consisted of distraction of the SBS, indirect treatment of the SBS, and the "Wagon-Tongue" technique which was most helpful along with a CV4. The cranium slowly responded and motion improved. The percussion hammer was applied to the cervical spine with the instructions to the patient to request that treatment stop if pain was increased. However, the treatment was tolerated well and the cervical spine released nicely. I was able to recreate the cervical referred pain by direct pressure on the upper cervical vertebrae. With indirect treatment the vertebral ligaments released and the cervical vertebrae regained their motion. The patient was sent home and instructed to return the next day and a CT scan of the head and neck were scheduled. At this time the patient experienced slight ataxia.

The working diagnosis at that time was neuritis of C2, C1 and CN V due to significant somatic dysfunction of the cervical and cranial ligaments. The CT was ordered to rule out any cervical or intracranial space occupying lesions.

The following day the patient reported full range of motion of the cervical spine and a complete resolution of pain until 7:00 AM. It was the longest time he had been able to not

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take pain medication and still feel comfortable. The patient was experiencing slight ataxia and his other symptoms remained but with less intensity. He also complained of feeling that he had to work at understanding and manipulating his environment rather than having responses be automatic.

Physical exam showed a man in mild distress; no change was noticed in his neurologic status other than slight ataxia. The examination of the cranium demonstrated the same fascial strain pattern but with a significant reduction in severity. The most difficult task was to get the occiput to move. Again the percussion hammer was used but this time on the sacrum to attempt to free the dura from the very forceful downward pull. The very strong pull of the dura was impressive. The patient responded well to the application of a CV4 and indirect treatment of the SBS. He was instructed to return the next day. I also felt that in spite of the severe dysfunction in his cranium he had excellent health and vitality. He had a lot of energy with which to heal and a strong desire to improve. He agreed that he had the same perception of himself and found it reassuring to have that perception confirmed. I informed him that I would call him as soon as I was informed of the CT result. He expressed his desire to drive to Baltimore and take a neuroscience exam that he had been studying for during the week and wanted to make sure he could have an appointment after the test. I assured him we could accommodate him but expressed concern over his performing an hour drive. I offered a written medical excuse which was denied.

That afternoon the radiologist informed me that the CT showed a lesion in the brainstem. The differential diagnosis was multiple sclerosis, a primary tumor such as glioma (gliomas in the brain stem are unusual in adults), or a metastatic lesion. I called the patient and informed him that he had an abnormality of the brainstem and an MRI would be scheduled for him the next day to evaluate him further.

The next morning an MRI was performed. At 1:00 pm the radiologist called to inform me that the diagnosis was most consistent with viral encephalitis. The brain was diffusely swollen, with diffuse demyelination, and marked swelling of the pons. He warned of the potential for hydrocephalus and uncal herniation. I called the patient who was not home and left a message for him to call me immediately. At 3:00 pm the patient called, he had driven to Baltimore and taken his neuroscience exam. I informed him of the diagnosis, referred him to a local neurologist and he was admitted to the hospital.

Upon admission to the hospital spinal fluid and blood was collected and tested for infection. Steroids were administered to immediately relieve the intracranial pressure and inflammation. No evidence of bacterial infection was identified from laboratory examination of spinal fluid or from cultures of spinal fluid or blood. Since the patient had spent time in Michigan over the summer where he fished and walked in the woods Lyme disease was considered and the patient was treated with IV Rocephin.

The final diagnosis was subacute meningoencephalitis of unknown origin, probably viral. The most likely virus is EBV. EBV would have caused the sore throat, the high fevers, and is known to appear to resolve and then recur. The patient will continue to receive follow up osteopathic care to prevent long term sequelae.

Discussion

The pons contains the spinal tract of the trigeminal nerve which is responsible for the sensation of pain and temperature. The pons also houses the seventh and eighth cranial nerves. Thus this patient's symptoms of ataxia and facial pain were easily explained by the swelling of the pons. The irritation to the first and second cervical nerves, I believe, was secondary to the tremendous strain of the dura and not an unrelated coincidence. These nerve roots were clearly inflamed along with their dural attachment and probably suffered from ischemia due to compression.

I believe that the reason this otherwise healthy man became so ill at this time in his life was due to the emotional and physical stresses in his life. He was studying hard for physical therapy school and neglecting the discomfort he felt in his neck. The somatic dysfunction of the cervical spine lead to stasis of the fluids within the tissues and made it possible for infection to take hold. He also had been experiencing increased emotional stress because the approaching holidays placed him in conflict with family obligations. Who is to say if he had received osteopathic care during this stressful period if the infection could have been avoided altogether?

I was impressed that osteopathy was able to improve his symptoms. I am reminded that A.T. Still did not have the luxury of MRI exams and steroid medication. Who is to say that the application of the CV4 and other osteopathic techniques would not have allowed this patient to continue to improve even if medical treatment had not been provided. When powerful medications are available to immediately treat acute illness it is wise to use them but it gives me great satisfaction to know that the time honored application of osteopathy can provide great benefit. ❑

[Editor's Note: Dr. Somner is a graduate of the NYCOM and is currently in private practice specializing in OMM with an emphasis on osteopathy in the cranial field. Her office is located in Bethesda, Maryland.

NOF Announces 1993-94 Mead-Johnson Bristol Myers Squibb Scholarship Winners

Six osteopathic physicians have been selected to receive the 1993-94 Mead Johnson-Bristol Myers Squibb Fellowship Grants, and each will receive a $5,000 research award administered by the National Osteopathic Foundation (NOF).

Established by a grant from Mead Johnson-Bristol Myers Squibb to NOF, the program assists DOs in securing advanced specialty training. In addition to the grant, each recipient will be honored at an Awards Breakfast hosted by Mead Johnson-Bristol Myers Squibb at the American Osteopathic Association's (AOA) Annual Convention and Scientific Seminar. The award recipients are:

Christopher Almeida, DO, of Saint Barnabas Hospital, Bronx, N.Y., for the study "Improved Treatment for Shoulder Impingement Syndrome."

Richard R. Kovar, DO, of Oakland General Hospital, Madison Heights, Mich., for the study "Myofascial Release of the Transverse Carpal Ligament in Carpal Tunnel Syndrome."

Billy W. Strait, DO, of Kirksville College of Osteopathic Medicine, Kirksville, Mo., for the study "Treating Carpal Tunnel Syndrome Patients with Osteopathic Manipulation."

Paul D. Tortland, DO, of University of New England College of Osteopathic Medicine, Biddeford, Maine, for the study "Osteopathic Manipulative Management of Carpal Tunnel Syndrome."

Robert T. Walsh, DO, of Mt. Clemens General Hospital, Mt. Clemens, Mich., for the study "Longitudinal Doppler Evaluation for Selection of High Risk Pregnancy."

John H. Windsor, DO, of Delaware Valley Medical Center/Deborah Heart and Lung Center, Browns Mills, N.J., for the study "Local and Systemic Treatment with Steroids After Coronary Angioplasty in Swine: Effects on Restenosis."

Two alternates also were selected. They are:

Raymond V. Harron, DO, of Bi-County Hospital, Warren, Mich., for the study "A Comparison of Transcranial Doppler Ultrasonography to Cerebral Angiography for the Evaluation of Cerebrovascular Occlusive

Burke G. DeLange, DO, of Osteopathic Medical Center, Ft. Worth, Texas, for the study "Arteriovenous Fistula Occlusion in Relation to Dry Body Weight and Central Venous Pressure in Hemodialysis Patients."

Mead Johnson-Bristol Myers Squibb Fellowship Grant awardees are selected by NOF's Committee on Educational Grants, which includes DOs and representatives of AOA and NOF.

In 1994, the name of the grant will be changed to the Bristol Myers Squibb Fellowship Grant. It will continue to be administered by NOF to benefit osteopathic physicians and researchers.

Since 1949, NOF has been instrumental in fostering a better understanding of osteopathic theory and practice. NOF provides loans and scholarships to students and administers research grant programs for scientific and clinical research.

Students, researchers or others interested in learning more about grants and scholarships available from NOF may contact Jackie Weiss, NOF, 5775 Peachtree-Dunwoody Road, Suite 500-G, Atlanta, GA 30342; (404) 705-9999. ❑

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AAO President Receives Award of Appreciation

(L-R) Paul F. Benien, Jr., DO, President of the Oklahoma Osteopathic Association, presents Herbert A. Yates, DO, President of The American Academy of Osteopathy, the Association's Award of Appreciation at their 93rd Annual Convention April 22, 1993.

During the Oklahoma Osteopathic Association's 93rd Annual Convention held at Shangri-La Resort in Afton, Oklahoma, Herbert A. Yates, DO, FAAO, (Tulsa, Oklahoma), received the Oklahoma Osteopathic Association's Award of Appreciation in recognition and honor of his commitment, service, and leadership to the osteopathic medical profession as evidenced by the American Academy of Osteopathy (AAO) electing him President for 1993-1994.

Dr. Yates is certified by the American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine and the American Osteopathic Board of General Practice. He has a private structural consultation practice in Tulsa, Oklahoma. In addition, he chairs the Osteopathic Principles and Practice Department at Oklahoma State University College of Osteopathic Medicine (OSU-COM), where he holds a position as Associate Professor of general and family practice. Dr. Yates graduated from OSU-COM in 1977 and completed internship training at Hillcrest Health Center in Oklahoma City.

An Academy member since 1981, Dr. Yates has served the AAO in numerous capacities including the Board of Trustees, Board of Governors, Awards Committee, and the Osteopathic Medical Economics Committee. He also participates in the Academy's Visiting Clinician Program and was program chairman for the 1990 AAO Annual Convocation. Additionally, Dr. Yates holds memberships in the American Osteopathic Association, the American College of General Practitioners in Osteopathic Medicine and Surgery, the Oklahoma Osteopathic Association, and the Oklahoma Chapter of the American Academy of Osteopathy. ❑

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may be spaced. This is another candidate for the programmed calling list with the instruction to the patient to call you if the patient to call you if the patient needs care before the calling program falls due again.

Another group of patients is the one prone to taking a cold. There are factors such as diet, occupation, areas of somatic dysfunction, habits, etc. that make people susceptible. When we run into such a patient, many of these factors should be considered.

... pay attention to the effectiveness of OMT ...

Above all, the somatic dysfunction of the upper spinal and cranial areas must be examined. Many of these patients can be made less susceptible by eliminating the somatic dysfunction on a regular basis in the spring or fall. The patient should get an OMT within hours after the first symptoms appear and in this way many times abort the cold or cut it short of running full course. Personally my experience has been very good and worth much to the patient.

Another group of patients on which OMT works with visible benefits are those susceptible to "flu" viruses. Each year a new strain of virus makes a methodical march across our nation devastating work schedules, killing the aged, etc. The use of OMT does one thing that can't be duplicated. The OMT enhances the production of antibodies and is empowered to make those capable of destroying that particular virus.

This experience illustrates what OMT can do. A family believing in osteopathic care called asking if I could come to the home and care for a flu patient. The patient was not a believer, and when I walked in, he said, "I don't believe osteopathy can help this kind of disease, and if I don't get better, I'm going to call a doctor." I told him that was fine with me and gave him an OMT. I made the mistake of not warning him that the OMT would increase the body's response to the infection and that he would feel worse for a few hours including increased temperature. The next day when I called, the MD was just finishing his diagnostic work-up. He folded up the case and took off. Since there was no viral medication, no prescription was given. The patient was again treated. The next day his temperature was closer to normal and he felt much improved. He asked me when he was going to start coughing up all "that stuff" that I do for three weeks after I get over the flu. I assured him that his body had already aborted that sequence. In another day or two he was again behind his desk as an attorney. We cut his "down" time by a half or two-thirds. I like that!

Another service can be given with OMT. A female patient came complaining of thoracic pain and discomfort in the T5-9 area. The history revealed that she was set up for elective surgery due to gallbladder disease in about a month. It was suggested, therefore, that she schedule at least 3-4 OMT between now and then. This was done. About two months later (after the surgery) the patient called to report her progress. She looked and acted well and healthy . She reported that on the third day after surgery the surgeon sat on the edge of her bed and asked what she had done to experience the surgery and recover so quickly. She told him that she didn't know of anything special except for taking 3-4 OMT before surgery. Of course, that didn't say much to a medical surgeon, but it sure did for me. The five or ten minutes for this service (OMT) is small for the benefit derived.

One experience taught me to pay attention to the effectiveness of OMT. A doctor from France was here visiting my practice so he could return home to use the osteopathic principles in his practice. His wife and four children came with him. He asked me to treat her thoracic pain centered at T10. She had gone through a clinic or two with no findings. Exquisite tenderness was present on the spine of the vertebra along with viscerosomatic somatic dysfunction. As diligently as possible I couldn't eliminate these findings . I suggested she be re-examined on arrival home. Two or three months later a letter informed me that tuberculosis had been found in the kidneys. Believe what the body tells you!

Believe what the body tells you!

Another welcome use of OMT is prophylaxis. In talking to managers of an industry it becomes apparent that "off" or "sick" times is a very real entity to be considered in the profit and loss columns. Those workers who have come for regular OMT find they are less prone to pains, strains, colds, influenza, etc. than they were in the

past. Once per month after the body has been mobilized should suffice. These people can be put on the programmed call list with stipulation that they come in earlier if needed - don't put it off. Some of these probably would do well on a two-month schedule instead of one. Keeping track of your patients makes better business and happier patients.

Are you troubled with allergies in your practice? Who isn't? Here again, after these have been worked up and you have found the offending substance and have made your program of do's and don'ts and have given prescriptions, etc., then add a regular regimen of OMT. Especially note the cranial, cervical areas and the area of T9 for somatic dysfunction affecting the function of the adrenal glands. The point here is to find the timing of the heaviest occurrence of allergies and concentrate your OMT program in this period of time.

Another group of patients is the female population with the complaints of pain and discomfort and irregular menses. The area of the spine to be concerned with is that between T10 and the middle of the sacrum. The lumbar segments and the pelvic joints are to be looked at carefully. In the case of irregularity, etc., the area of T10 and upper lumbar are very important in normalizing the function of the ovaries. Sometimes structural imbalance is a factor and needs evaluation in every new case. For the timing of OMT, the first thing is to mobilize the areas of somatic dysfunction. Then maintain on a monthly basis for awhile as needed just before the period sets in.

How many of your patients have flat feet that wear them out on a daily basis with pain and discomfort? OMT will many times change this picture markedly. Do it.

One area of application of OMT is almost never considered and that is in skin disease. Here again, the blood supply to skin is important in the treatment: of dermtoses, etc. This can occur in the lower extremity and be changed with OMT. Ulcers have been eliminated more quickly with OMT. Be very sure in skin diseases that persist that there is no somatic dysfunction associated with the area by nerve supply.

In a high percentage of cases OMT can reduce the distress

Constipation is a scourge of adult life and old age. Of course, we need to consider diet, fluids, activity and many other causes of stasis. Any somatic dysfunction between T8 and L4 can easily diminish colonic activity. This probably is chronic and should be programmed accordingly.

One of the things that has really pleased me is being able to treat someone and make him well enough to cancel some elective surgery, such as herniated disc. One didn't do this often but I remember one case in which the patient was back on the loading dock until he retired a short time ago. Oh, it took us nine months to get it done but we both loved it. Other joints yield to careful OMT. The problem should always be studied and tried before cutting into the joint. Once that is done, it limits "normal" recovery.

A distressing entity that many times is resistant to any program is asthma. In a high percentage of cases OMT can reduce the distress. This includes infantile asthma and that of older age. The treatment diminishes the severity of attacks and many times diminishes the frequency of attacks. After a few minutes of OMT, it is pleasing to see the more comfortable relaxed expression instead of the fearful anxious expression. Regular regimen of OMT is necessary in chronic diseases of this type. Space the treatments 3-4 weeks apart with instruction to call in if an attack occurs before the scheduled time. This schedule should be put into place only after adequate mobilization is accomplished.

Pneumonia can be troublesome. The hospitalized patient should receive OMT every six hours at the least. Not more than two minutes each time. If respiratory embarrassment is present, more often for a minute or two helps. Just keep from fatiguing the patient at any one time. The OMT is applied wherever you find the patient - sides or back. Just enough pressure is used to relax the musculature. After improvement has started, one may use passive movement of rib and cervical and upper thoracic joints. Again, this should be brief and nontraumatic. Temperature may rise after the first OMT but after that (3-4 hours) a gradual decline occurs. This may vary with the age of the patient and the length of time after the onset of the infection. I like to see a reaction but warn the patient. You'll find the pneumonia is shortened.

The new mother that is short of

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breast milk for breast feeding can be helped by treating the thoracic area. The number and type of OMT will depend on the age of the patient and the age and cause of somatic dysfunction in the thoracic area. Mobilize the joints as early as possible. Treatment of this area should be included in the pre-delivery OMT's to shorten and ease delivery time and effort. No pregnant woman should go to delivery without mobilizing, the lumbar and pelvic joints. The treatment regimen should be put in place after the first visit to the obstetrician. Five to ten minutes OMT scheduled for each of eight months prior to delivery will pay off in shortening delivery time. They help three people - the doctor, the mother, and the infant - in more ways than one.

While I have pregnancy on my mind, let me ask you a question. Which is better for the pregnant mothers - to let them sit around while work around the home goes undone because they are half sick and fatigued all the time or to give them OMT and remove these symptoms and the frustrations of living in hopeless surroundings for nine months?

For sometime in my practice, I practiced next to a doctor who was an artist in handling endocrine problems. He and I worked together on a number of endocrine cases. The addition of the osteopathic manipulative treatment was a definite stabilizing entity in the treatment regimen of a fragile case. This list of endocrine problems spanned all ages from infants to old age and included problems of the thyroid, gonads, pancreas, etc. Never neglect somatic dysfunction related to any endocrine gland. These many times are chronic in nature and the program for OMT should fit this factor. Treat frequently (daily if necessary) to mobilize, then maintain as dictated by the findings by palpation, etc. of the somatic dysfunction.

Many times concern is increased when an inactive person, as in a hospital bed, manifests any arrhythmia. A minute or two with OMT to the left side of the third thoracic will either stop the irregularity or prove that increased concern is valid. Not always does it work that quickly but it is worth the effort of what actually is going on in the heart's regulating system.

The retarded child many times is dismissed with the thought there is nothing that will be of benefit. I recall one such case that walked only by holding furniture and unable to help herself. After 2-3 months of regular OMT to areas of somatic dysfunction, she was taking off across the room giving her brother a hard time and was much more self-sufficient. It took quite a bit of load off the mother.

Another group of patients is those with torticollis. I don't recall of having completing eliminating the malady in either infant or the young adult, but making the position of the head less obtrusive is worth a great deal to the patient. This is a chronic entity and the OMT program must be set up to fit. Patience ... Patience ...

Much is being done about infertility. Thirty days has been adequate time in many cases to eliminate somatic dysfunction that has prevented fertilization. Both the male and female need OMT in many cases. This type of malady has not been adequately treated without OMT as part of the regimen. Adequate mobilization with a maintenance dosage of 2-3 months many times will do.

Spondylolisthesis can't be cured by OMT but treatment here and there take the dull ache and back fatigue out of many cases. The patients are grateful for any help.

Another group of patients is distressing to themselves and the doctors and dentists. This group sleeps face down and rests their head on a hand on the pillow or sits reading the paper with a chin in hand over an elbow, traumatic episodes as in accidents, falls, etc. One case I recall I took about four months to re-align the lower jaw with the maxillary dental ridge so a new set of dentures could be made that fit. Cranial manipulation can be handled in a similar fashion as any OMT to other joints of the body. That refers to the amount of time it takes to give a cranial OMT and the amount of force used in some techniques. Intra-oral manipulation is very effective.

In this area, intra-oral manipulation, has a beneficial effect on the eustachian tube, the ear drum, ringing in the ear and dizziness. Also reaching up behind the soft palate into the eustachian fossa and stretching the surrounding muscles opens the tubes to drain. The lymphatic drainage is enhanced, making the whole area more nearly normal in function.

Now there are others but these give good examples of what any DO can do. Above and beyond this are the many occupational stresses and injuries, auto accidents, accidents about the home, athletic injuries, and the everyday stresses of living and their affect on the soma.

Remember the soma is the tool the patient uses to make a living. It is also the "read out" or display panel that informs the physician of areas of poor function internally and externally. Keep it so the patient can use it effectively. ❑

Message from the Executive Director ... *continued from page 7*

++ Program Chairman **John Glover** consulted with the Committee to refine the program for the 1994 Convocation scheduled for March 23-26 in Colorado Springs. He proposed that the AAO sponsor two Visceral Manipulation Courses — a three-day introductory course and one-day advanced course — featuring **Jean Pierre Barral**, DO, who also has been booked as a speaker for Convocation. These additional courses would be scheduled on the weekend prior to Convocation. The Committee charged him to move forward with the proposal which must be submitted to the Board of Trustees for its approval.

++ The Committee reviewed with program chairpersons the content of meetings scheduled for the next 18 months:

* OMT Update - September 16-19 in Orlando
* 1993 Convention - October 11-13 in Boston
* Basic Percussion Vibrator - November 6-7 in Indianapolis
* Cruise/CME - January 15-22, 1994 in the Carribean
* OMT Update - February 12-13 in Indianapolis
* 1994 Convocation - March 23-26 in Colorado Springs
* Advanced Percussion Vibrator - July/Aug (tentative)
* OMT Update - September 22-24 in Orlando
* Basic Percussion Vibrator - October (tentative)
* 1994 Convention - November 14-16 in San Francisco
* Tutorial - January (tentative)
* OMT Update - February (tentative)
* 1995 Convocation - March 22-25 (site TBA)

** The American Osteopathic Association's Graduate Medical Education Conference, to be held September 10-12 in Chicago, will feature a presentation by the Academy's "A-Team" of Raymond Hruby, Mark Cantieri and Laurie Jones. AOA President Laurence Bouchard is the Chairman of a national conference on the teaching of OPP/OMT which recommended that the topic be addressed at the GME Conference entitled "Osteopathic Medicine: New Beginnings Toward Quality Education." Conference Chairman Robert George invited the "A-Team" to deliver a shortened workshop similar to the one the group presented at the AOHA meeting last May. The program was designed to assist hospital CEOs and DMEs in increasing the delivery of OMM in the hospital setting. (By the way, Laurie Jones dubbed the group as the "A-Team" after the popular television series featuring the champions of causes for the "underdogs.")

** Have you volunteered to work a couple of hours at the AAO Structural Consultation and Treatment Service during the 1993 Convention in Boston? Chairman David Musgrave once again has solicited volunteers for this popular service which attracts many physicians and friends of the profession. Please return the volunteer form which was mailed with the last issue of The AAO Newsletter or drop us a note indicating when you will be available. This is a terrific opportunity to increase the visibility of the Academy within the profession while, at the same time, providing a valued service to your colleagues.

** COMP VIEW, the newsletter of the College of Osteopathic Medicine of the Pacific, carried an informative article in the Summer 1993 issue entitled "Alumni Survey Determines OMT Use in Practice." The Alumni Affairs office surveyed 902 DO alumni and received a 38 percent response. Of the 159 alumni who indicated that they used OMT in their practice of medicine, the following breakdown of percentage of use on patients was:

% of Patients Seen	% of Alumni Polled
< 5%	27.7% (43)
5-25%	39.9% (63)
25-59%	13.3% (21)
50-75%	7.0% (11)
75-100%	12.7% (20)

Respondents also included alumni who were enrolled in postgraduate training programs. Of these 104 alumni who said they were permitted to use OMT in their training programs, 90 said that they actually used it; 14 do not practice OMT, even though they have permission. Of those who utilize OMT, 3 (3.3%) use it only in the treatment of inpatients; 37 (41.1%) use it only in the outpatient setting; and 50 (55.6%) said they use OMT in both settings.

One other item of note was that 166 respondents (50.8%) indicated that they seek OMT treatments for their own personal health.

** In the August 2, 1993 issue of American Medical News, the AMA featured Stephen C. Gleason, DO, who is a 47 year old family physician from Des Moines. President William Clinton appointed Dr. Gleason to head a review group of 47 health professionals to critique the reform plan from the provider's perspective. It is significant that President Clinton chose an osteopathic physician to head this group and I highly recommend the short profile to you. However, I cite this feature primarily as an illustration how an individual physician became politically active to change the status quo. This same opportunity is available to all AAO members, whether the cause be within or outside the osteopathic profession. I continue to urge you to consider seriously your active involvement in your local, state and national osteopathic organizations. ❑

Delegates Make History

Academy Votes at AOA House of Delegates

At the President's Reception honoring incoming AOA President Laurence Bouchard (third from left), AAO leaders (l-r) Eileen DiGiovanna, Judith O'Connell and Herbert Yates pause for a photo.

Past President **Judith A. O'Connell** represented the Academy at the American Osteopathic Association's1993 House of Delegates Meeting in Chicago last July. President **Herbert A. Yates** served as the AAO's Alternate Delegate for the historic meeting in which representatives of AOA practice affiliates were seated as voting members of the House for the first time.

The Academy was well represented at this meeting. In addition to Drs. O'Connell and Yates, President-elect **Eileen L. DiGiovanna** and Executive Director **Stephen Noone** attended both the AOA's Board of Trustees and the House of Delegates meetings to represent the Academy's views on a variety of resolutions. AAO Associate Executive Director **Diana Finley** promoted Academy interests at a meeting of the Association of Osteopathic State Executive Directors. UAAO President **Anita Eisenhart** and National Advisor **Ruth Jones** spoke to student issues and represented the UAAO at meetings of the Council of Student Council Presidents and Student Osteopathic Medical Association.

With the meeting just concluded, AOA President-elect William G. Anderson (center) stops to be greeted by Academy representatives (l-r) Eileen DiGiovanna, Herbert Yates, Ruth Jones and Steve Noone.

Adding to the Academy's visibility this year was the presence of the AAO's Structural Consultation and Treatment Service on Friday and Saturday. Administrative Assistant **Lisa Rader** staffed this popular service. AAO members **John Hohner** and **Ken Nelson** volunteered many hours of their time to provide treatments to delegates and guests, while 12 other Academy leaders and members who were part of their states' delegations also donated their services to provide a total of 44 treatments. The SC&TS was highly praised and was requested to return for the 1994 House of Delegates meeting in Atlanta where it would be located in a more prominent location.

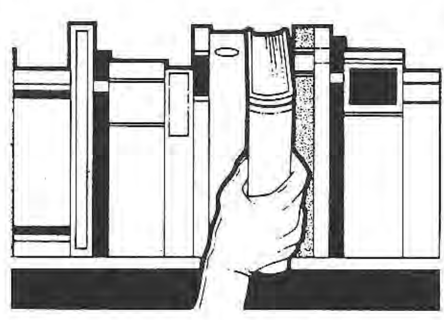
In an analysis of 1993 delegates, the AAO staff identified a total of 52 AAO members who were representing their states, a 27 percent increase over last year's total of 41.

During the House of Delegates proceedings, AAO Past President Judith O'Connell (left) reviews a Resolution advocated by Matt Weyuker, executive director of the Osteopathic Physicians and Surgeons of California.

The Lesion

from *Principles of Osteopathy*
G.D. Hulett, DO
Journal Printing Company
Kirksville, MO 1906

By osteopathic usage the word lesion has acquired special significance. The *surgical conception* of lesion, any hurt or injury to a part, and the *pathological concept*, any local or circumscribed area of tissue undergoing abnormal functional changes, must be carefully distinguished from the osteopathic concept which is any *structural perversion which by pressure produces or maintains functional disorder.* Note first that the definition includes all tissues. While it is true that the bony lesion occupies first place by virtue of history and importance, *muscular and ligamentous perversions* are rivals of the former for preeminence. A *viscus* may act as a lesion, and among the most serious of diseases are those directly dependent upon pressure from *prolapsed viscera.* In the second place note that the structure must be perverted, that is, not normal--has departed from the usual or average condition. Third, note that the condition of function is included in the conception of lesion. This is of fundamental importance. From what has been said in a previous section it can be understood that a structure may be perverted in the sense of being unusual and still not be a cause for change of function. This variation is still within the limits of normal adaptation. A spine may have its curves markedly exaggerated or completely obliterated and the functional conditions still remain normal. To make of it a lesion in the osteopathic sense there must be included the idea of functional disorder as a consequence of the structural perversion. Finally, note that the disorder is produced by pressure. This latter idea is the keynote in disease causes. We believe this conception of the term lesion is the proper one from the standpoint of usage, convenience, and simplicity.



The perverted structural condition may be a disturbed **positional relation** of parts. These may be further classified into (a) *dislocation,* which usually refers to bony tissue and represents a condition in which there is a completed separation of the articular surfaces. An example of this class would be a hip dislocation. (b) *Subluxation*, also usually referring to bony structures but in which there is an incomplete separation of the articular surfaces, is a second type. A rib is more commonly subluxated than dislocated. (c) *Displacement* is more commonly applied to yielding structures and especially viscera in which there is no well marked or special articulating surfaces. It is more appropriate to speak of a displaced uterus than of a subluxated or dislocated one. (d) The lesion may be in the nature of a contracture, more especially of muscle tissue. While it is true that all living tissue is more or less susceptible to change in shape through the phenomenon of contraction, muscle tissue because of its specially developed power in this particular must occupy first place. While the contracture is a position change it is also a size change and might appropriately be considered in the next division. For there is undoubtedly in the majority of muscular contractures an increase in the total bulk of the muscle though not necessarily in the amount of muscular fiber.

In the second place the disorder may be a disturbed **size relation** of parts. These may be also further classified into (a) lesions from *overgrowth*. In the case of a hypertrophied heart or a thoracic aneurysm direct pressure is exerted upon the lungs and other thoracic structures with resulting disorder of their function. (b) *Arrested growth* and (c) *atrophy* are less common conditions but are occasionally noted. In the case of an atrophied liver the resulting disturbance of associated abdominal viscera may be directly dependent upon this size disturbance. (d) *Perverted growths*, as in the case of exostoses and tumors which are special forms of overgrowth conditions, are considered as lesions. ❑

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Saturday, January 15, 1994 (on shore)

7:30 am	Registration opens
8:00- 8:30 am	Course & Faculty Introduction and Overview
8:30- 9:15 am	Diagnosis of Somatic Dysfunction with Terminology Review
9:15-10:00 am	Coding for Diagnosis and Reimbursement
10:00-10:15 am	Break
10:15-11:00 am	HVLA Technique Principles: Indications and Contraindications
11:00-12:00 noon	Spinal Biomechanics
12:00 noon	Adjourn

Sunday, January 16, 1994

8:00- 9:00 am	Lumbar & Pelvis Anatomy, Motion Characteristics and Diagnosis
9:00-10:15 am	Pelvis Workshop (hands-on)
10:15-10:30 am	Break
10:30-12:00 noon	Lumbar Spine Workshop (hands-on)
12:00- 1:30 pm	Lunch
1:30- 5:00 pm	Thorax & Ribs
1:30- 2:30 pm	Anatomy, Motion Characteristics and Diagnosis
2:30- 3:45 pm	Thoracic Spine Workshop (hands-on)
3:45- 4:00 pm	Break
4:00- 5:00 pm	Ribs Workshop (hands-on)
5:00 pm	Adjourn

Monday, January 17,1994

8:00-12:00 noon	Cervical Spine
8:00- 9:00 am	Anatomy, Motion Characteristics and Diagnosis
9:00-10:15 am	Lower Cervical Workshop (hands-on)
10:15-10:30 am	Break
10:30-12:00 noon	Upper Cervical Workshop (hands-on)
12:00 noon	Adjourn

Thursday January 20, 1994

8:00- 1:30 pm	Extremities
8:00- 9:00 am	Anatomy, Motion Characteristics and Diagnosis
9:00-10:15 am	Upper Extremity (hands-on)
10:15-10:30 am	Break
10:30-12:00 noon	Lower Extremity
12:00-12:45 pm	Complete Treatment Approach
12:45- 1:30 pm	Course Wrap-Up (Questions and Answers)
1:30 pm	Adjourn

We Need National Health - Not National Health Insurance

by Robert C. Clark, DO

[Editor's Note: Dr. Clark is a 1977 graduate of Kirksville College of Osteopathic Medicine and currently is in the private specialty practice of Osteopathic Treatment and Physical Medicine in Upland, California.]

It is ironic as the epitome of socialized nationalized health care, the Soviet Union, is making a rapid if not meteoric conversion to the free market system, the United States on the other hand seems to being falling toward the now failed socialist model. We note the "paragon" of nationalized health care, Great Britain, has a rapidly growing private second tier of health care, where demand and ability to pay, NOT a self-serving bureaucracy, determine who gets care.

The highly touted Canadian system has a large number of its residents crossing the border into the U.S.A. for prompt, high quality, but "costly" treatment. Why do Canadians cross the border to buy what they can get for free? A common answer is they choose to receive their care when they want it, not when the rationing bureaucrats are willing to give it. Alternatively, what they want is not allowed to them due to age or other arbitrary restriction built into the "cost effective" Canadian system.

But all systems of health care have a significant failing and that is of providing health. Almost all medical systems concentrate on treating disease and often futilely fighting the inevitable after the battle is lost. Nearly no one is concerned with health. Not even the euphemistically misnamed "health maintenance organizations" promote health. HMO's merely provide bargain basement approaches to episodic disease treatment.

Despite the overly publicized ravings of politicians and the press, there is no health care crisis; however, there is a health care financing problem. We have a nation of people who want the best money can buy, "Neiman-Marcus" quality of care, but want it for less than "Wal-Mart" prices. It is time for radical changes in health care financing to encourage private practice to survive. It is essential to have *HEALTH* nationally! Doctors everywhere should call for healthy living and even more, they should practice what they preach.

Specifically, we should stop smoking, we should eliminate or reduce intake of alcohol. Exercise activities and fitness should be part of the work-day and the work-place. All workers should take frequent productivity enhancing breaks of a couple minutes approximately every 15 to 20 minutes. The rationale of this action is found in education. The adult learning new material has a maximum attention span of 20 minutes. The better teachers package their lectures and class presentations in 12 to 15 minute packets. Stress management should be taught and practiced on the job in all jobs.

We should broaden our treatment perspective to involve patients more in their care. After all the responsibility for the patients' well-being is the patients', not the doctors'! Doctors are the experts who guide them, but we can not make the decisions for them. To that end we must, at the legislative level return responsibility to the patients and end the government's support of unhealthy practices. For example, the farm programs subsidize the production of tobacco while the surgeon general's office is placing health hazard warnings on tobacco products. If the Congress truly wants to improve health and reduce health care expenses, start by ending the subsidy for producing a known cancer causing substance that kills thousands each year. Another end to the tobacco subsidy would be to exclude smokers from the "Black Lung" program. I recall my student days when one of our pathology lecturers said that he couldn't tell the difference between the lungs of a smoker or a black lunger. Carbon deposition is carbon deposition. Let us not make the tax payer pay for the care of a person who has purposely chosen to live a fatal life-style.

We must open our treatment horizons to truly improve and maintain health. Classical Osteopathy with its manipulation, and Chiropractic, offer treatments that are designed to maintain function of the physical body. These treatments are based in history with success where other more "conventional" methods have failed to help the patient recover from some dys-

function. And many practitioners and patients experience preventive medical benefits.

We need to design total health maintenance using all the branches of the healing arts; be it medicine, osteopathy, chiropractic, naturopathy, homeopathy and so on. Many of the so called "Alternative or Complementary" methods have ardent followers and demonstrated successes where other more conventional methods have failed. Last year, I read about a case in Ohio where an insurance company refused to pay for chelation therapy for a patient with coronary artery disease. The court found for the patient and the decision blasted the insurance company for not honoring its commitment to the patient who had followed the insurance company procedures to the letter. This patient had been diagnosed with coronary artery disease and advised to have bypass surgery. The patient obtained the required second opinion which recommended chelation therapy. The patient decided to have the less invasive chelation therapy which was successful. The insurance company refused to pay. The judge was incensed. The patient, in seeking a second opinion found a safer and cheaper treatment that was effective. The company was forced to pay.

The point is we must never close our eyes and our minds to alternatives. After all, our goal should be the health of the patient with the least invasive and stressful treatment we can provide, no matter its type or source. If we were to subject the "approved" or "recognized" treatments for many diseases to the criteria of proof that we demand from alternative therapies, we might very well discover that which we hold dear would fail our own test. Why, for example, do we ask for remission of cancer from alternative therapies when currently recognized therapies do not themselves give us remission? Essentially we of medicine must remove our own biases and prejudices.

As we pursue national health we must ask some very hard questions. Questions such as, "Is it worth a million dollars in pediatric or neonatal intensive care unit costs to prolong the life of an infant or child that has no real hope of surviving, and even if it did would require around the clock hospital care to continue to live?" Or "Should drug addicts and alcoholics get medical and hospital care at taxpayer expense for their continued abuse of these chemical substances? Is the greater good of society really served by keeping repeat abusers alive if by their actions they show us they want to kill themselves?" We must also look at the very costly issue of the terminally ill. It has been said that 90 percent of Medicare money is spent on the last one month of the patient's life. If there is truly no hope and the patient is indeed terminal, "shouldn't we try to make their last days as comfortable and pleasant as possible rather than try to prolong the life and suffering and delay the inevitable?" I believe that this question, if asked of the American public, would find that most people would choose to minimize the intervention for the terminally ill and let nature and life take their natural courses to the inevitable end; however, attend the patient by keeping him or her comfortable and pain free. The number of living wills requesting withholding artificial life prolongation seems to increase each day.

Lastly as part of the path to national health, we must look after the doctors who help the patients. Serious reform to malpractice should be part of the process. As patients assume the privilege of more responsibility for their own health, they must assume the risks of that responsibility. Unforeseen or undesirable outcomes should never be the grounds for a malpractice suit. If a doctor errs and harms a patient let the settlement be quick and equitable, but limit it to no more than the cost of the "botched care" and the actual loss sustained by the patient. It seems strange that an obstetrician has to fight to get paid a couple thousand dollars for successful prenatal care and delivery. But if the baby is not perfect, even if it is God's fault, then he is likely to be sued for a million dollars.

We must also remove the risk of practice placed upon doctors by third parties such as insurance companies and government. We are not their employees and do not receive the benefits that their employees do. But we are subject to their arbitrary and capricious behavior, policies and rules which of course they never tell us about until after the fact because it is against their policies and rules to tell us. It seems strange that we must buy our supplies at retail, pay costs at retail but insurance companies pay us what they want and when they are good and ready. It is time that changes — they should pay us at retail too! They shouldn't be allowed to fix prices as they do. They shouldn't be allowed to refuse to pay after the fact because some person who is paid by them to say that the care we gave wasn't necessary makes that decision without ever seeing the patient. After all if I were paid by an insurance company to say that someone's care was unnecessary, I would do so because that is what I was hired to do.

The path to national health is in our long term best interests as doctors and as patients. We have hard questions to ask and answer. We must be open to new or alternative treatments. Patients must accept responsibility for their own actions and health. When we harm a patient we must make amends but not be ruined in the process. We must focus on health not

disease. We must become doctors who truly care for and befriend their patients as we did many years ago. We must be freed from the arbitrary vagaries of insurance companies and paid for our work fully and promptly.

Lastly, we as doctors should not be greedy for more and more money, but at the same time we must never be ashamed that we are well paid. After all, eight or more years of training with no income during that time must be paid for somehow. The typical medical student graduates with debts of $50,000 to $80,000 and that too must be paid. Don't forget that a doctor who is self employed, on the average, employs two to five people. With all the doctors, hospitals, pharmaceutical companies and related health business, the U.S. Health Care System is the greatest employer in the country. And the next time someone says a doctor makes too much, ask them if $750,000 for a local TV sportscaster or $10,000,000 for a movie star's single performance or an athlete's salary or $40,000,000 for the CEO of Disney is too much?

I am proud to be a Doctor of Osteopathy. I specialize in Osteopathic Manipulative Treatment or what some today call physical medicine. Every day I do things to help people feel better, function better and frankly live better. For some I am their last hope at anything resembling a normal life. Too many of my patients think I am a miracle worker. It is exciting and rewarding to do what many people, both patients and doctors, think is impossible, but then I do it all the time. It is frustrating to have to fight with insurance companies, Medicare and lawyers, who are ignorant of what I do, to get paid for my work especially when I get results that no one else could achieve. I find it a bitter irony that a surgeon can do a surgery and get paid five to ten times an hour what I do and with many times less hassle than I get.

For now the reward of doing good and helping people recover their function and their lives outweighs the problems and hassles. But there are some days when I wonder why do I persist in being a doctor in private practice. Fewer people want to be responsible for their well being. Fewer people are willing to pay a fair price for what I do. I have to make enough to pay my costs of being a doctor; rent for office, supplies, phone bills, electric bills, business insurance, business licenses, medical licenses, governmentally mandated refresher courses each year (50 hours worth), travel to such courses, self employment taxes and equipment taxes. I am careful so only one-half of what comes in the door goes out as overhead. But then right now at least the remainder is cut in half by taxes. I buy my own retirement plan and health insurance. I have no paid days off. Why do I continue being a doctor? Sometimes I wonder . . . ❑

NOWPA Meets in Tucson

The National Osteopathic Women Physician's Association held its 1st Leadership Seminar at the Loew's Ventana Canyon Resort in Tucson, Arizona, May 28-30, 1993.

The Jones Group of California presented an informative seminar titled "The Power of I Am". Laurie Jones was the main speaker while Dr. Mary Theodoras, President of NOWPA, moderated small group discussions on Saturday night.

Forty seven participants attended including two OUCOM students, and two male physician members. An evaluation survey taken after the seminar concluded it was an overwhelming success. The participants are eagerly planning to return next year as the membership of NOWPA continues to grow.

Anyone interested in joining the NOWPA should contact Dr. Judy Lewis, 1618 N.E. 80th Street, Seattle, WA 98115.❑

AOA House of Delegates Elect Officers at July Meeting

Laurence E. Bouchard, DO

Laurence E. Bouchard, DO, a Narragansett, Rhode Island, osteopathic family practitioner, was elected president of the American Osteopathic Association (AOA) at the recent AOA House of Delegates meeting in Chicago.

As the newly elected president, Dr. Bouchard plans to continue the AOA's dedication to promoting primary care. "The osteopathic medical profession is well-equipped to step forward and act as a model for primary care as well as our history and heritage all exemplify the excellent job we do in training our primary care physicians," said Dr. Bouchard.

Dr. Bouchard is a police surgeon and town and school physician in Narragansett. He serves on the boards of trustees of both the Rhode Island Society of Osteopathic Physicians and Surgeons and the New England Foundation of Osteopathic Medicine. He is the past assistant regional dean of clinical affairs for the University of New England College of Osteopathic Medicine, Biddeford, Maine.

He has served the AOA as chairman of the American Association of Colleges of Osteopathic Medicine and is a member of the American Academy of Osteopathy.

As president-elect he served the AOA as a member of the bureau of finance, the committee on administrative personnel and the president's advisory council.

A 1962 graduate of the Kirksville College of Osteopathic Medicine, Dr. Bouchard completed his internship at Cranston General Hospital in Cranston, Rhode Island. He received his undergraduate degree from the University of Buffalo.

William G. Anderson, DO, FACOS

William G. Anderson, DO, FACOS, an osteopathic surgeon, was recently elected president-elect of the AOA.

Dr. Anderson has served as president of both his county and state osteopathic associations and for the past ten years has served as a trustee of the AOA, chairing its strategic planning committee and its bureau of state governmental affairs. He has distinguished himself as a leader of osteopathic health care in Michigan through his role as director of governmental affairs for Detroit Osteopathic Hospital and his professional affiliations.

Dr. Anderson has had a 27-year career of general and surgical specialty practice. He formerly served as a consultant and senior attending surgeon at many Detroit area hospitals. He also held many positions at Michigan Health Care Corporation over a twenty-two year period where he was chief of surgery, chief of staff and chairman of the board of directors.

Currently, Dr. Anderson is the associate director of medical education at the Detroit Riverview Center in Michigan and is president of Life-Choice Quality Health Plan, HMO in Detroit.

Dr. Anderson has also made contributions to the civil rights movement. As a close friend of Dr. Martin Luther King, Jr., he spearheaded the establishment of the first NAACP Youth Council at the Atlanta University in the late 1940's. Dr. Anderson was also the founder and first president of the Albany Movement which worked to desegregate southwest Georgia in the early 1960's. He was director of the Southern Christian Leadership Conference from 1963 until 1969.

Dr. Anderson is a 1956 graduate of the University of Osteopathic Medicine and Health Sciences, College of Osteopathic Medicine and Surgery, in Des Moines, Iowa. He is a Fellow of the American College of Osteopathic Surgeons. ❑

In Memoriam

Robert W. Gates, Sr., DO

Robert W. Gates, Sr., DO, retired osteopathic physician died at home, July 21, 1993. Dr. Gates retired in 1989, having practiced in the Tampa Bay area since 1953. He was a staff member at University Community Hospital, and Good Samaritan Hospital, Tampa; Metropolitan General Hospital, Pinellas Park.

Dr. Gates was born in Ft. Lauderdale, Florida. He earned his DO degree from Kirksville College of Osteopathic Medicine.

He was a member of Sigma Sigma Phi, National Scholastic Honor Society and Alpha Tau Sigma Fraternity. Dr. Gates was a Fellow of the American College of Osteopathic Family Physicians and held life memberships in that organization as well as the American Academy of Osteopathy, Florida Academy of Osteopathy, American Osteopathic Association, Florida Osteopathic Medical Association and Florida Society ACOFP.

Dr. Gates was an active member of Temple Terrace United Church; member of Kiwanis International for 43 years; member of Doric Lodge #140 F.& A.M., Ft. Lauderdale and Community Lodge #292 F.& A.M., Tampa; Egypt Temple Shrine and Scottish Rite, Valley of Florida. He served in the Hospital Corp., U.S. Navy, during World War II.

Survivors include his wife of 45 years, Alice Hendrix Gates; two sons; Robert W. Gates, Jr., of Tampa and Rev. Lawrence T. Gates of Charlotte, North Carolina; one daughter, Alice Claire Teague of St. Petersburg; one brother, Dr. T.H. Gates of Thomasville, Florida and seven grandchildren.

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Highlights of AAO Program in Boston October 11-13, 1993

Walter C. Ehrenfeuchter, DO, FAAO
Program Chairperson

"How to Fix Feet - Form, Function and Foul-ups"
"Horseback Riding Therapy"
"Characteristics of the Cranial Rhythmic Impulse in Healthy Humans"
"Musculoskeletal Manifestations of Operative Complications and Manipulative Management of the Post-Operative Patient"
"Effects of Manipulative Treatment on Computer Enhanced Somato Sensory Evoked Potentials"
"Love, Medicine and Miracles"
"Peace, Love and Healing"
"State of the Academy Address"
"Getting What They Owe Us; Coding and Collecting for OMT"
"Psoriatic Arthritis"
"Cutaneous and Soft Tissue Manifestations of Occult Spinal Dysraphism"
"Physiologic Mechanism for the 'Red Reflex' Skin Response"
"Northup Lecture"
"Cutaneous Manifestations of Somatic Dysfunction"
"Use of Botulinum Toxin in Unremitting Post-Traumatic Muscle Hypertonicity"

CLASSIFIED ADS

DO Wanted!

DO wanted to experience rural health care in remote mountains of West Virginia. Beautifully forested community of Man, 80 miles from state capital in Charleston. Family practitioner needed to provide primary care services to catchment of 30,000 people. Multi-specialty group or hospital-employed practice. Salary $80,000 to $100,000 with paid personal/professional insurances and other major benefits. Work with friendly people who have APPRECIATION FOR YOUR WORK and need your help. Send CV to or call: Greg Davis, Appalachian Regional Healthcare, P.O. Box 8086, Lexington, KY 40533 1-800-888-7045 or (606) 281-2537 collect.

Southeastern Mass

PAIN TREATMENT CENTER is seeking a qualified Osteopathic physician to take over the busy and lucrative OMT practice. Excellent working conditions and virtually no call. Contact: William E. Dworet, DO (508) 994-8493.

Cranial Osteopath Wanted !

Opportunity available for Cranial Osteopath to join an established, OMT-based, holistic group practice in Maryland suburb, north of Washington D.C. Call Osteopathic Associates (301) 587-7072 weekdays.

Boston Area

BOSTON AREA: Seeking one or more physicians to take over a thriving OMT practice. Comfortable office in a small town/suburb just outside Boston. The patients are accustomed to osteopathy in the cranial field, but would welcome any ongoing osteopathic care. If interested contact Dr. Rachel Brooks (617) 646-2320.

DO Needed !

Opportunity available for a Family practitioner to be part of a busy practice at the River Valley Clinic in Northfield, MN. Must be willing to do OMT. River Valley Clinics are owned by Health One in Minneapolis. Contact: David Flicek, Administrator, 1400 Jefferson Road, Northfield, MN 55057, (507) 645-2095.

Las Vegas, Nevada

Immediate opening for Physician skilled in Osteopathic Manipulation in busy 2 Doctor practice in Las Vegas, NV. Practice specializes in industrial injuries, motor vehicle accidents and soft tissue injuries. Trigger point injections/OMT/Physical Medicine Modalities are utilized. Comprehensive benefit package available. Contact: Janet Fishman, Administrator (702) 876-2225 or Fax (702) 879-9307.

Osteopathy in the Cranial Field Los Angeles

Growth opportunity for osteopathic/family practitioner in wholistic group practice in San Fernando Valley of Los Angeles. There are no other osteopaths who practice strictly OMT modalities in the area. Multi-specialty group enjoys modern offices with first-class amenities and established, high quality patient base. Call/write: Dr. Carol Port, Executive Director, Wholistic Health Institute, 15165 Ventura Boulevard, Suite 335, Sherman Oaks, CA 91403; (818) 905-5755.

Books, Skeletons and Skulls Needed

We are pre-doctoral anatomy and OP&P fellows at UNE-COM and plan to practice family medicine emphasizing manipulation. We are interested in acquiring osteopathic books, skeletons and skulls. Please call or write Gretchen Sibley and Ralph Thieme, OP&P Department, UNECOM, Biddeford, ME 04005; (207) 283-0171 ext 533.

ENCOURAGE YOUR COLLEAGUES TO BECOME BOARD CERTIFIED IN OMM

CALENDAR OF EVENTS

SEPTEMBER

10-12

Midyear Seminar
Florida Osteopathic Medical Association
Hyatt Regency Westshore, Tampa
CME credit, 20 hours 1-A anticipated, including five hours of mandatory Risk management and three hours of mandatory HIV/AIDS.
Contact: FOMA Executive Office
(904) 878-7364

10-14

Introduction to Esoteric Healing: Part I
This is the first in a series of four courses that teach the principles and techniques of Esoteric Healing. The course will be taught by the International Health Research Network. The course will be held at the Park inns International Hotel, East Lansing, MI
Contact: Barbara Briner, DO
(517) 349-7377 after 7:00 pm.

11-12

"Clinical Experiences in Osteopathy"
Puget Sound Academy of Osteopathy
Seattle, WA
Contact: Maureen Thomson, DO
(206) 441-3270

11-13

4th Annual Mid-Year Seminar
"Who's Managing the Medical Store"
Osteopathic Physicians & Surgeons of California
CME Credit: 17 (Category 1-A)
Contact: OP&S of California
(916) 447-2004

13-17

Basic Cranial Course
"The Expanding Osteopathic Concept: Basic Cranial Course
Director: Viola Frymann, DO, FAAO,
COMP campus, Pomona, CA
Contact: Jane Riplog
(800) 447-2667

16-19

OMT Update/Board Prep Course
American Academy of Osteopathy
Walt Disney World Resort Club Villas
Orlando, FL
CME: 22 Hours (Category 1-A)
Contact: Diana Finley
AAO, Associate Executive Director
(317) 879-1881

18

1993 Fall CME Program
"OMT Techniques"
Rocky Mountain Academy of Osteopathy
The Broadmoor
Colorado Springs, CO
CME Hours: 7 (Category 1-A)
Contact: Charles B. Schaap, DO
(303) 771-3102

30-October 3

22nd Annual Convention
New England Osteopathic Assembly
Hyatt Regency Hotel
Old Grennwich, CT
Contact: Nancy Dickey
(207) 474-2357

OCTOBER

8

AOA Board of Trustees
Boston, MA
Contact: Ann Wittner
Director of Administration, AOA
(800) 621-1773

9

AAO Board of Trustees
Boston, MA
Contact: Stephen Noone, CAE
Executive Director
(317) 879-1881

10

AOBSPOMM Examinations
Boston, MA
Contact: Stephen J. Noone, CAE
Executive Director
(317) 879-1881

10-14

AOA/AAO Convention
Boston, MA
Contact: Diana Finley
AAO, Associate Executive Director
(317) 879-1881

NOVEMBER

6-7

Basic Percussion Vibrator Course
American Academy of Osteopathy
Indianapolis, IN
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

12-14

"Introduction to Visceral Manipulation"
Puget Sound Academy of Osteopathy
Seattle, WA
Contact: Maureen Thomson, DO
(206) 441-3270

JANUARY

15-22

Cruise/ Basic ODT Program
American Academy of Osteopathy
Eastern Carribean
CME Hours: 20 (Category 1-A)
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

FEBRUARY

4-6

AAO Education Committee
Headquarters Building
Indianapolis, IN
Contact: Stephen J. Noone, CAE
Executive Director
(317) 879-1881

12-13

OMT Update/Board Prep Course
American Academy of Osteopathy
Embassy Suites Downtown
Indianapolis, IN
CME: 22 Hours (Category 1-A)
Contact: Diana Finley
AAO, Associate Executive Director
(317) 879-1881

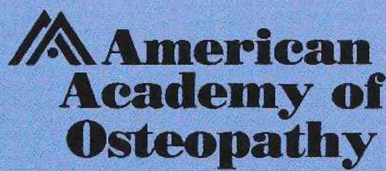
19-20

AAO Long Range Planning Committee
Headquarters Building
Indianapolis, IN
Contact: Stephen J. Noone, CAE
Executive Director
(317) 879-1881

MARCH

23-26

Annual Convocation
American Academy of Osteopathy
Colorado Springs, CO
Contact: Diana Finley
AAO, Associate Executive Director
(317) 879-1881



Important Dates to Remember

September 16-19, 1993
Third Annual OMT Update:
Board Preparation Course
Orlando, FL

October 10, 1993
AOBSPOMM Examinations
Boston, MA

October 11-13, 1993
AAO 1993 Convention Program
Boston, MA

November 6-7, 1993
Basic Percussion Vibrator
Course
Indianapolis, IN

January 15-22, 1994
Cruise/Basic ODT Program
Eastern Caribbean

February 12-13, 1994
OMT Update:
Board Preparation Course
Indianapolis, IN

March 23-26, 1994
Annual Convocation
Colorado Springs, CO

For More Information, please contact:
The American Academy of Osteopathy
(317) 879-1881

American Academy of Osteopathy
3500 DePauw Blvd.
Suite 1080
Indianapolis, IN 46268-1136

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