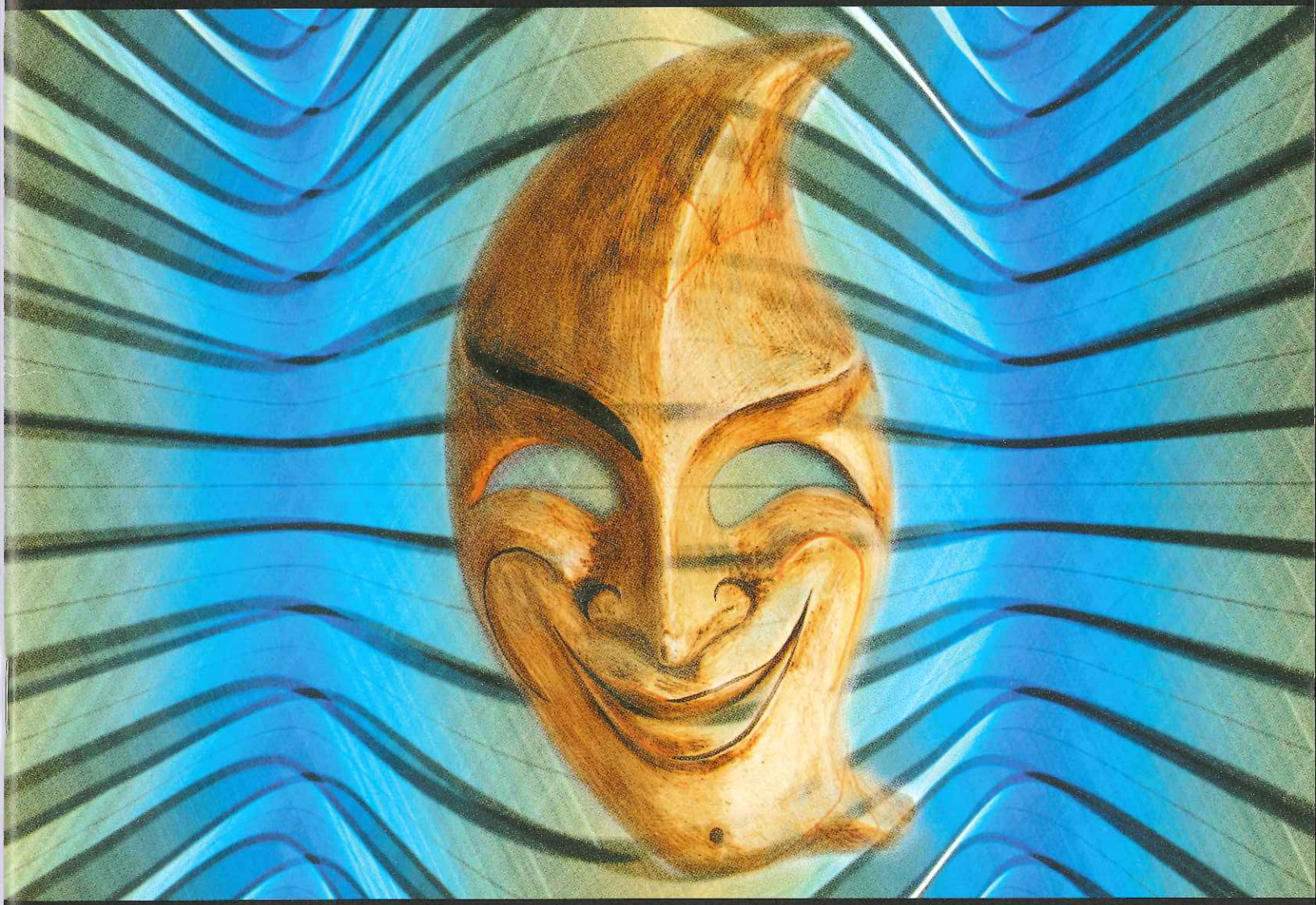
THE AAO
JOURNAL
A Publication of the American Academy of Osteopathy

VOLUME 4 NUMBER 3 FALL 1994



A Rational Look at Cranial Rhythmic Impulse

...see page 9

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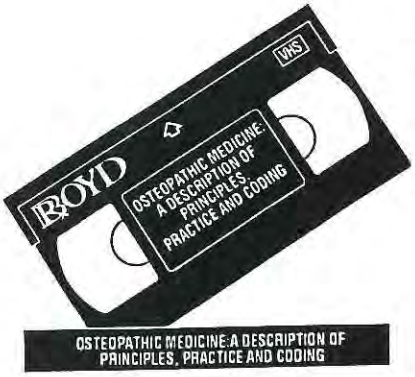
Osteopathic Medicine:
A Description of Principles, Practice and Coding



Sponsored by the American Academy of Osteopathy , this video program is designed to assist State and Local Associations and individual osteopathic physicians in educating third party payers, healthcare regulators and policy makers about osteopathic diagnosis and procedures.

This video covers the following topics:

- ***What is a DO?***
- ***What is the osteopathic difference?***
- ***How osteopathic (OMM) diagnosis and treatment work.***
- ***Why the need for rediagnosis at each patient visit.***
- ***Use of the new 1994 CPT codes.***

Presented in language understandable by the sophisticated lay person, this program should be presented to every third party payer that has ever questioned an osteopathic diagnosis or procedure. For state legislators and health-care planners, regulators and policy makers, this program is an invaluable aid to understanding osteopathic medicine and OMM.

The video medium is utilized to demonstrate specific examples of osteopathic diagnosis and treatment emphasizing the uniquely osteopathic approach to the whole person. This is a program you can show to anyone who has wondered about our profession.

Osteopathic medicine: a description of principles, practice and coding is available now at pre-publication prices. In addition, an AAO member discount is available as well as additional discounts for volume purchases. This is a tool DOs have long needed — please support this project and give yourself a good pre-publication discount, by ordering today!

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The *AAO Journal* is the official quarterly publication of the American Academy of Osteopathy (3500 DePauw Blvd., Suite 1080, Indianapolis, Indiana, 46268-1136). Third-class postage paid at Carmel, IN. Postmaster: Send address changes to American Academy of Osteopathy 3500 DePauw Blvd., Suite 1080, Indianapolis, IN., 46268-1136

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.

From the Editor

A. T. Still and Quality

by Raymond J. Hruby, DO, FAAO

We hear a lot of talk about quality these days. Many organizations have implemented programs to improve the quality of their products or services and to provide better customer service. They have discovered that continuously striving to improve products and services is the key to success. That may seem like a obvious statement, but if you look around you can find plenty of instances where businesses cannot or will not accept the idea of continuous quality improvement. In current phraseology, they just don't get it.

There have been a number of well known people the years who have championed the cause of quality improvement. One of the commonly used methods for developing a quality improvement program was developed by a gentleman by the name of Walter Shewhart. He is known for what is called the plan-do-study-act (PDSA) cycle of quality improvement. Shewhart perceived improvement as a continuous cyclical effort based on *planning* a change, which includes identifying and defining the problem, investigating the problem by collecting valid data from a sample, and analyzing the data to identify causes and solutions. The second step is to select a best solution and *carry it out (do)* on a small scale. The next step, *study*, is to observe the results from the proposed solution, collect data and study the results. Then *act*, that is, adopt the change that seems a probable solution, or abandon it or try it again under different circumstances. Then *plan*: begin the cycle again with renewed effort or broaden the effort and continue the cycle until the problem is resolved. Application of this cycle insures thorough consideration of problems and possible solutions.

It should come as no surprise to us that Andrew Taylor Still was an expert at quality improvement. We have all heard the story of how he developed the science of osteopathy. We know that he did not set out to start another profession. Rather, he wanted to improve the practice of medicine in his time. So right from the start, Doctor Still was seeking to increase the quality of healthcare. He follow the Shewhart cycle before it was invented. He saw a problem with the way medicine was practice, and he planned for a change. He spent years studying the situation, gathering information. Then he carried out his plan within his own practice. Then Doctor Still studied the results, and since he saw that he was successful he decided to adopt his plan for the improvement of medical care.

Because Doctor Still was so successful, there was a great demand for his services. This presented another problem: how to deliver this better form of healthcare to the public? His initial plan was to offer his system of care to the medical profession of the day, but he was rejected. So he formulated another plan, which was to start a school. He then acted on his plan, and the school was opened. He studied the results achieved by the graduates of the school, and saw that they were highly successful. He then acted on these results by deciding to continue to train more osteopathic physicians. Thus Doctor Still had realized his goal, which was to deliver his new methods of treatment to the public.

By applying the plan-to-study-act cycle in this fashion, Doctor Still again demonstrated his foresight. His ability to seek solutions to problems in this fashion led to the founding of a profession that has benefited untold numbers of people over the years. We should all use these principles to continuously improve the quality of the care we give our patients. ❑

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

We encourage and welcome computer disks containing the material submitted in hard copy form. Though we prefer Macintosh 3-1/2" disks, MS-DOS formats using either 3-1/2" or 5-1/4" discs are equally acceptable.

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1. References are required for all material derived from the work of others. Cite all references in numerical order in the text. If there are references used as general source material, but from which no specific information was taken, list them in alphabetical order following the numbered journals.

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.

Editorial Processing

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

Dear Dr. Hruby:

On behalf of the Osteopathic Librarians' Special Interest Group, representing the colleges of osteopathic medicine and the osteopathic hospitals, I want to thank you and the American Academy of Osteopathy for the journal samples you contributed for our exhibit booth at the Medical Library Association Conference held May 13-18, 1994, in San Antonio, Texas.

The journals generated great interest in osteopathic medical education, the differences between DOs and MDs, and the philosophy of osteopathic medicine. This was the first year the Osteopathic Librarians' SIG sponsored a booth, and the response to our presence and the publications displayed was overwhelmingly positive.

We hope to sponsor an exhibit booth at the 1995 Medical Library Association Conference, which will be followed by the Seventh International Congress on Medical Librarianship, in Washington, D.C. This double event will provide a special opportunity to increase the visibility and awareness of the osteopathic medical professional and literature.

Thank you again for your contributions to the success of our exhibit.

Sincerely,
Sharon Eckert
Technical Services Coordinator
Jack S. Ketchum Library
University of New England

In Memoriam

Ralph M. Gordon, DO

Dr. Ralph M. Gordon, 85, of Salem, Oregon, passed away February 23, 1994.

A native of Pawnee City, Nebraska, he graduated from the University of Nebraska and later from Kirksville College of Osteopathic Medicine and Surgery in 1934. He served on its Board of Trustees for 12 years and then was a trustee emeritus.

From 1934 to 1940, he practiced medicine in Estes Park, Colorado. Dr. Gordon was the first DO in Salem in 1940. He served on the Board of Medical Examiners for Oregon for 10 years.

He retired February 10, 1994, then suffered a severe stroke.

Dr. Gordon was a life member of the American Osteopathic Association and a long-time member of the American Academy of Osteopathy. Dr. Gordon was a member and held every office in the Kirksville Osteopathic Alumni Association. He was a member of the Shriners, Rotary Club and Westminister Presbyterian Church, all in Salem.

Survivors include his wife, June; daughter, Pat Humphrey of Medford; sons, Bob M., Gordon of Kona, Hawaii, Bob Sigler of Mission Viejo, California and Craig Sigler of Modesto, California; 10 grandchildren and 15 great-grandchildren

Private interment was in Belcrest, Mausoleum.

The American Academy of Osteopathy extends its deepest sympathy to Dr. Gordon's family.❑

Message from the President

Eileen DiGiovanna, DO, FAAO

There is concern expressed everywhere about the state of health care in America. You read about it in the newspaper and hear about it on radio and T.V. Where is it all going? What is going to happen to the physicians? Will there be limits imposed on our practices? There certainly will be on our incomes.

I was pleased to note the activity going on at the AOA. The Board of Trustees and the House of Delegates dealt with many resolutions that are aimed at protecting members. There has been hiring of persons who are very knowledgeable about governmental policies and other health care concerns. They are actually becoming proactive in their efforts to see that all osteopathic physicians are included in health care legislation, are introduced in a positive light to managed care insurers and attain their rightful place in the health care system of the future.

A very important step they have taken, for which Academy members can be grateful, is the hiring of Nancy Edwards who has done a great deal for us regarding coding issues. She has solved many of the medicare problems which have been plaguing a large number of states. She is now looking at individual insurers and worker's compensation carriers to try to resolve ongoing problems with payments for manipulation.

Academy members were very active and politically prominent at the meeting of the AOA House of Delegates' meeting. It is wonderful to see the Academy taking a position at the forefront of the decision making.

As in the California crisis of the sixties, DOs are, once again, uniting to fight for a common cause. The unique identity of the osteopathic physician must be preserved for the benefit of all the patients who rely on osteopathic care for their health needs.

Each of you can contribute by contacting your senators and representatives and urging them to support HR173 and all the other legislation which protects our rights. Support the AOA in the work it is doing for us. Make your concerns and needs known to us here at the Academy so we can respond. United we can go far!❑

Please...to keep your mail coming and our records straight, be sure to let us know if you have a new name, home, office, FAX or telephone number!

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Message from the Executive Director

Stephen J. Noone, CAE

The Ram of Reason is alive and well!

In his autobiography, Andrew Taylor Still wrote "While in that sleep I dreamed that an old ram of great power hit me a jolt on the side of the head, and sprawled me out full length." He went on to describe how that ram had a significant influence on his subsequent decisions. This brief story in Still's *Autobiography* inspired the AAO to adopt the "Ram of Reason" as a symbol of the Academy's position within the osteopathic profession.

As I reflected on the performance of the Academy's leadership and membership at the 1994 AOA House of Delegates Meeting in Atlanta, I recalled Dr. Still's story and thought it described their activities appropriately. Your leadership has achieved significant respect for the Academy's positions on issues which are deliberated by the AOA Board of Trustees and House of Delegates. Last month this was evident not only on the Academy's four resolutions, but also on items submitted by divisional societies and other practice affiliates. I urge you to express your gratitude to the Academy's delegation who have served you well — President **Eileen DiGiovanna**, President-elect **Boyd Buser**, Past President **Herbert Yates** and Alternate Delegate **Judith O'Connell**.

While I reported this information in the August AAO Newsletter, I believe it is important enough to repeat the results of the Academy's resolutions were:

1) **Allopathic Postdoctoral Training in OMM**

This resolution and accompanying position paper responded to Resolution 241 from the 1993 House of Delegates which directed the Academy to propose a "mechanism whereby allopathic physicians and surgeons may take postdoctoral training in osteopathic manipulative medicine (OMM) which leads to appropriate credentialling by the AOA through the American Osteopathic Board of Special Proficiency in OMM."

The House of Delegates referred the Resolution to the Committee on Basic Documents of Affiliated Organizations and the Bureau of Professional Education (Council on Postdoctoral Education) for study. A report will be made to the AOA Board of Trustees at their November 1994 meeting and recommendations for implementation to the July 1995 House of Delegates.

2) **Use of the Term Osteopathy**

In advertising in *The D.O.* magazine, the Academy has been prevented from using the term "osteopathy" due to a policy from the July 1960 House of Delegates. This Resolution called for a revision of that policy statement to permit the use of the terms "osteopathy" and "osteopathic medicine" as interchangeable.

The House of Delegates adopted the Resolution as presented. Hence, the use of the terms "osteopathy" and "osteopathic medicine" are interchangeable.

3) **Osteopathc Credentialling**

Osteopathic credentialling has increasingly come under attack, with DOs being denied hospital privileges or enrollment in managed care plans due to their training and certification not being ABMS-approved. This resolution called for the profession to seek federal anti-discrimination regulations **and** to explore alternative residency training programs to accommodate those DOs who want to earn certification while still in practice.

The House of Delegates strengthened the Resolution by calling for the profession to "*seek enactment* of federal and state anti-discimination *legislation* that requires recognition of AOA certification." The second part of the Resolution dealing with alternative residency training programs was deleted since the AOA's Bureau of Professional Education was already considering the adoption of such programs.

One of the Academy's Resolutions did not pass — **DO as the sole degree**. The AOA Board of Trustees reaffirmed its Bureau of Professional Education's decision to permit colleges of osteopathic medicine to offer the degree Doctor of Osteopathic Medicine (D.O.) at the option of the individual institution (in fact, UMDNJ-SOM already awarded the new degree in 1994.) The Academy's Governors had opposed this decision on the basis of the profession's achievement of universal recognition for its *Doctor of Osteopathy* degree as well as a sincere concern over the potential labor and cost of changing language in federal/state statutes and regulations which make reference to Doctor of Osteopathy. Proponents, including the American Association of Colleges of Osteopathic Medicine and the Council of Student Council Presidents, felt that Doctor of Osteopathic Medicine was a better description of the earned degree. A spokesman for the AOA Board of Trustees outlined the Board's and colleges' research on changing statutes and regulations, stating that it was only a matter of technical corrections to document the change as an equivalent degree. The House of Delegates defeated the Academy's resolution by a substantial majority. ❑

A Rational Look at Allopathic, Osteopathic and Basic Science Literature on

The Cranial Rhythmic Impulse and Headache: A Synthesis for Clinicians and Scientists Working Toward Mutual Education

by James Andrew Lipton, DO, CSPOMM, LCDR, MC, USN*

Dr. Lipton has developed a multi-disciplinary career as a naval officer, basic science and clinical faculty member teaching anatomy and osteopathy and as a student of allopathic physical medicine. This paper was submitted as partial fulfillment of the requirements for Fellowship in the American Academy of Osteopathy.

Introduction

In this paper, a rational look will be taken at the cranial rhythmic impulse as well as a major problem in the United States: headache. A common ground will be created across disciplines so that we may advance our understanding and justify that effort. in relation to just one of the many diagnoses which warrant our attention in this manner. The reader is urged to remember that a great many clinicians and scientists feel strongly in helping patients in the manner in which they were trained and excel, and can provide within the constraints of their particular practice, experience and means.

One thing we all share, regardless of the sense we rely upon, is that we approach the human body throughout time subject to certain universal natural laws and are, as yet, subject to certain variable laws of humankind affecting health care. In search of understanding the former and adapting to the latter, let us see how the literature intersects with these topics and, in doing so, align emphasis and direction in establishing cost-effective and appropriate care for the benefit of the patients.

Cranial Rhythmic Impulse

William Garner Sutherland, DO, D Sc, (Hon.) lived from March 27, 1873 to September 23, 1954. He recognized what has been described as the cranial concept after entering the American School of Osteopathy at Kirksville, Missouri in September, 1898. He credited his inspiration to Andrew Taylor Still, the founder of osteopathic medicine, who exhibited a disarticulated skull from which Sutherland formulated a variety of thoughts using his powers of observation. These thoughts included his view of the relationship between the articulations of the skull, dura mater, cerebrospinal fluid, respiration and health. The publication of his ideas in the *Cranial Bowl*[89] was a precursor to the dissemination of his ideas in a variety of osteopathic circles.[63]

Subsequently, Magoun[62] compiled Sutherland's teachings regarding the cranial concept.

The study of the cranial concept was said to begin with a basic understanding of the:

a. osteology and arthrology of the skull and sacrum
b. development and morphology of the central nervous system
c. structure of the meninges of the brain *and* cord
d. physiology of the cerebrospinal fluid
e. structure and function of the venous sinuses

A knowledge of osteopathy, defined as a system of diagnosis and therapy, based on the interrelationship of anatomy and physiology for the study, prevention and treatment of disease was interjected into the phrase "osteopathy in the cranial field".

Two physiologic phenomena were put forth and represent two key elements of thought, namely:

→

*The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Navy, Department of Defense or the U.S. Government.

a. There is motion present in cranial sutures.
b. A rhythmic impulse exists within the cranium manifested throughout the body and integrated into a unit of physiologic function known as the primary respiratory mechanism.

The primary respiratory mechanism was based on the phenomena of:

a. motile central nervous system
b. fluctuating cerebrospinal fluid
c. mobile meninges, cranial bones and sacrum

The term cranial rhythmic impulse came into use to account for cycles of expansion and contraction felt while palpating the head.[63,67,102]

"The Term Cranial Rhythmic Inpulse came into use to account for cycles of expansion and contraction felt while palpating the head."

In summary, there are common threads among Sutherland's teachings. In other words, there are crucial assumptions that underlie the clinical application of his ideas. These assumptions are condensed as follows:

a. Skull bones move.
b. Certain cranial and peripheral substances move in rhythms.
c. Palpatory sense reveals central and peripheral movement.

The reader is asked to refer back to these summary assumptions as needed in reading the text below.

A number of texts subsequently have described Sutherland's teachings and their clinical application.[15,29,32,62,90,91,92] A review of articles published on this subject gives further insight regarding the literature. Articles also exist describing Sutherland's teachings[4,23,39,53,72,99,105] and their clinical application.[43,54,60,103] Articles exist describing a knowledge of cranial anatomy with comments regarding cranial bone mobility and structure as a basis for applying Sutherland's teachings in the approach to medical and dental trauma and pathology.[24,46,56,57,58,59,61] Articles exist describing the application of Sutherland's teachings in the approach to medical and dental trauma and pathology.[24,46,56,57,58,59,61] Articles exist describing the application of Sutherland's teachings to the newborn and pediatric patient. These articles generally relate anatomical changes in regard to birth and, subsequently, can include case studies. Comments are made regarding the effect of structure on development in relation to the teachings of Sutherland.[25,26,97,101] Articles exist describing thoughts regarding the origin of inherent motion in the central nervous system[55,81] and describing a variety of comments in regard to cranial research.[40,45,66]

In short, there have been published well-reasoned thoughts describing Sutherland's teachings and their application. Now let us consider research articles in the literature examining aspects of Sutherland's teachings.

Articles exist studying the question of a relationship between the craniosacral examination and problems in newborn, pediatric and adult patients.[8,28,94] The effect of osteopathic medical management on neurologic development in children has also been studied to support the use of such treatment based on osteopathic medical philosophy and principles. The conclusions in this paper are made to support an assumption (which appears below) that the change in neurologic development is associated with somatic changes that accompany osteopathic manipulative treatment.[22] Has there been research which can be

related to the study of these osteopathic assumptions (see summary assumptions above) underlying Sutherland's teachings?

With regard to research into the movement of skull bones:

a) One line of study is that anatomically skull bones are capable of movement along suture lines. With regard to a few of the many articles in anatomy along these lines, particularly due to the work of Retzlaff and others, certain evidence is presented to provide an anatomic basis for sutural mobility. Chiefly, this evidence is the presence of tissue other than bone within cranial suture lines, rather than finding total ossification. Assumptions follow regarding the function of these tissues.[74,75,76,77]

A second line of study has been to observe physiologic movement of skull bones in animal and human experiments.[2,3,27,33,64,88] With regard to research into cranial and peripheral substances moving in rhythms:

b) Along this line, many research articles exist. One in particular is chosen as an example of an extensive review across disciplines.[5] Apparently, there are a number of central and peripheral substances which move and have in the past been subdivided into surface membrane and cellular oscillators. These oscillators range from cardiac pacemaker activity to the control of development and include not only glia, but also nerve cells and a variety of other relatively macro entities and underlying micro-substances centrally, peripherally and across a number of organisms.[5] Another line of research involves the movement of cerebrospinal fluid. Magoun mentions the work of Russian scientists, Speransky, Moskaenko and Naumenco in this regard.[63]

Further comments on updated research appear below.

With regard to research into palpatory sense revealing central and peripheral movement:

c) Studies have been completed which support the ability of examiners to palpate motion in a reproducible fashion.[69,70,80,95]

Well, where do we go from this point? A number of articles exist regarding why further research should be performed, by whom, how, when, where and on what.[6,19,31,41,42,71] Clearly, we only can justify the effort in today's environment if further research is important. In other words, why bother with CRI research? Is it important for the patient, to clinicians of all types, to scientists? Let us take a look at just one diagnosis which preoccupies the American public today. In doing so, perhaps selected physicians and scientists may gather in a cooperative effort to research the CRI.

Headache

The effect of headache on the population of the United States is worthy of concern. According to Stewart, et al,[86], 8.7 million females and 2.6 million males suffer from migraine headaches with moderate to severe disability. Of these, 3.4 million females and 1.1 million males experience one or more attacks per month.[86] According to Diamond,[14] during a cluster headache series a

"... 8,7 million females and 2.6 males suffer from migraine headaches with moderate to severe disability. Of these, 3.4 million females and 1.1 million males experience one or more attacks per month."

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patient may experience from one to eight headaches per day each lasting from 15 minutes to 3 hours. The patient does not need to be in poor health to suffer in this manner. The headaches can be post-traumatic and might even be based on a familial disposition. Debate continues on the origins of the post-head trauma or post-concussion syndrome.[14]

The Ad Hoc Committee on the Classification of Headache defines at least 15 types of headaches. The vascular types, including migraines, are classified on the basis of evidence supporting the view that cranial arterial distention and dilatation are implicated in the painful phase but cause no permanent changes in the involved vessel. Remaining classes involve the effects of skeletal muscle, structural and emotional tension, inflammation and a variety of insults to physiology.[1,35]

According to Smith,[84] The International Headache Society classifies 129 headache disorders covering all types of headache, cranial neuralgias and facial pain. Migraine is defined in category I and is subclassified into 14 types.

A reasonable approach to the headache patient involves taking the best available history including the location, character, severity, duration, frequency, triggering mechanisms and placing this information in proper context as a guide toward further action. Further action includes a detailed physical examination. Additional work-up does not necessarily mean a lot of diagnostic tests. Reasonable tests include a complete blood count. urinalysis, chemistry panel, erythrocyte sedimentation rate and imaging studies as appropriate.[98]

There are drug treatment approaches to the acute and chronic forms of headache. Prophylactic approaches with respect to migraines include the following:

1. Beta blockers (propranolol HCL, timolol maleate, atenolol, metoprolol tartrate and nadolol) some of which can be effective in reducing the frequency of attacks by more than 50 percent

2. Calcium channel blockers (diltiazem HCL, verapamil HCL, nimodipine and nifedipine)

3. Antidepressants (amitryptyline HCL, nortriptyline HC1, desipramine HCL and trazadone)

4. Angiotnesin-converting enzyme inhibitors

5. Nonsteroidal anti-inflammatory drugs

6. Clonindine

7. Some antihistamines

8. Monamine oxidase inhibitor (phenelzine sulfate)

Abortive approaches to migraine include ergotamine and isometheptene mucate which are vasoconstrictors. For tension headaches drug treatment includes the nonsteroidal anti-inflammatory agents (NSAIDS), antidepressants and muscle relaxants. Cluster headaches can be treated with vasoconstrictors, NSAIDS, lithium, calcium channel blockers, some antihistamines, phenothiazines and steroids. Severe pain can be controlled in the short term with narcotics/analgesics.[21,98]

Smith[84] notes that for the past 30 years research has focused on biochemical modulators of vascularity, particularly serotonin which acts as a stimulus for vascular alteration and as a neurotransmitter. Additionally, the role of neurons and their role in the pathology of migraines is considered to involve the whole brain with focal symptoms. He explains that at the beginning of an episode the frontal cortex and hypothalamus are affected producing prodromal symptoms followed by influences on visual and sensory cortex (aura) progressing to hypothalamic and brainstem effects of nausea, vomiting, fatigue and vasomotor disturbances. Researchers suggest that migraine pain is visceral in nature, and that the pain develops in the dura, provoking extracranial muscle spasm and altered blood flow.[7,73]

Along these lines, one of the newer drug approaches to the treatment of migraine and cluster headache is the serotonin antagonist sumatriptan.[10] Sumatriptan is chemically related to serotonin and shares a high affinity for the 5-HT1D and 5 HT1A receptors. The 5HT1 receptor is mainly localized in certain cranial blood vessels. In-vitro studies show constriction of meningeal circulation; this is consistent with the relief of migraine headache being tied to the meningeal circulation.[38]

Smith[84] goes on to note that some experts believe that headache is actually a spectrum with acute migraine at one extreme and tension headache at the other with overlap in the intervening types. A theory which he notes is becoming increasingly popular is there is a common basis

linking vascular and tension-type headaches. He notes elsewhere that oromandibular dysfunction is often associated with tension-type headaches.

Synthesis

Of note is the overlap among pharmacological approaches for the different headache types as well as the use of trigger point injections. Electromyographic studies of migraine and muscle contraction headaches found quantitative but no qualitative differences. Similarly, authors cite roles for various manipulative treatment for several kinds of headaches. The manipulations described can include high velocity low amplitude, counterstrain or osteopathy in the cranial field techniques as examples.[21,65,68] Could there be an overlapping relationship between the principles of drug treatment, the pathophysiology of headache and the cranial rhythmic impulse as we currently understand them? Magoun[63] quotes a paper from 1957 that involves the study of oscillations of glia, and the involvement of serotonin in mental processes.[104] In 1976, Retzlaff et al described a possible mechanism for the action of craniosacral manipulation altering vasomotor tone of arterioles.[78]

In a brief review of the headache literature much attention is paid to the phenomena of introducing man-made **chemistry** into the organism (drugs). That is, physicians take advantage of the laws of chemistry to effect internal biochemistry and thence a variety of processes and structures. Physicians who work with body posture are familiar with the macro effects the force of mutual attraction between all bodies proportional to the product of the masses of the bodies divided by the square of the distance between them **(gravity)**. What would you have said to the scientist who thought to work on the fluctuating pattern of fluid motion in the oceans on earth being related to interactions between the earth and the moon if he/she came to you first with the idea? Would you be part of the problem or the solution? Similarly, we have paid comparatively less attention in medical literature, for example, to micro-electromagnetic phenomena which by definition are subject to the laws of nature and equally inescapable in the human condition.

Let us examine **magnetism** as an example. The presence of an electric current induces a magnetic field. Further, many people have had the experience of placing two magnets in proximity and felt a grossly palpable sensation between the two magnets with or without them touching.

How does this relate to an understanding of the CRI? The answers are that the brain has a weak (less than the torso generated by the heart) fluctuating magnetic field, measured by the magnetoencephalogram in the range of 1x10-9 gauss.[11,12,13]

Are the magnetic fields each of us has definitely not playing a role in palpation and the flow of bodily fluids? The reader is urged to remember the author is neither a physicist nor conversant in magnetic experimentation. Please note, how-ever, we are discussing avenues for research and ways for scientists to provide mutual education. Currently, we are interested in why we palpate fluctuating and rhythmic sensations and their source beyond what we know.

In particular, researchers are urged to review the diagram in reference[12] labeled **fig. 3** in which directional magnetic fields secondary to alpha currents flow. Does this relate to palpation,[93,96] centrally and peripherally or for that matter influence CSF or venous flow?[34] There exists literature on the clinical use of magnetic waves.[82,100] This, however, is an old story awaiting new applications and understanding. Isabelle Chapello, DO, FAAO, educated this author years ago on the use of magnetic waves in wound healing; interestingly enough. this is being looked at again in at least one major allopathic institution involved in rehabilitation. Also, Magoun[63] quotes the work of Tromp in emphasizing the relevance of physics to medicine.

Many thoughts exist on pathophysiologic models in the selection of treatments.[37] In this paper, we can note that chemistry, magnetism, electricity and the elastic nature of structure may all be worthy of further study. However, if the reader really wants to get to the essence of the matter in the author's view, we are talking about macro and micro motion oscillation, the essence of life if you prefer. When viewed even at the subatomic level the common thread in all medical approaches regardless of perceived effectiveness is harmony taken in the sense of harmonics.

Underlying chemistry are physical laws of attraction, repulsion and oscillation. The beneficial effects of color, photo and music therapy are broken down into vibrating frequency. Robert Fulford, DO, is well known in the osteopathic profession and is a proponent of percussion treatments,

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National Osteopathic Foundation Names AAO President-Elect Boyd R. Buser, DO "Educator of the Year"

Mike Levin, Executive Director of the National Osteopathic Foundation (left), presents the Educator of the Year Award to Boyd R. Buser, DO, during the annual AOA House of Delegates' meeting in Atlanta, Georgia, in July.

Boyd R. Buser, DO, Associate Professor & Chairman of the Department of Osteopathic Manipulative Medicine at the University of New England College of Osteopathic Medicine (UNECOM), has been named the AOA/NOF Educator of the Year for 1994.

The Educator of the Year Award recognizes DOs for their contributions to osteopathic medicine and education, and to public health. The award is given annually to one outstanding educator in osteopathic medicine. The recipient must exemplify and encourage the principles of osteopathic medicine.

The American Academy of Osteopathy nominated Dr. Buser president-elect at its Annual Convocation in Colorado Springs this past March.

He is board certified by the American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine and the American Osteopathic Board of Family Practice.

In 1977, Dr. Buser received his undergraduate degree from the University of Iowa, and graduated from the College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1981, where he also completed a fellowship in osteopathic manipulative medicine. After finishing his internship at Cranston General Hospital Cranston, Rhode Island, Dr. Buser was Assistant Professor of Family Practice at the University of Osteopathic Medicine and Health Sciences in Des Moines. He also served as the director of several clinics in Des Moines before assuming his current position at UNECOM.

Dr. Buser's professional affiliations include the American Osteopathic Association (where he has been an editorial consultant since 1989), the American Academy of Osteopathy (where he currently serves on the Board of Trustees and the Board of Governors, as well as many committees), the New England Academy of Osteopathy (where he served as both vice president and president, the Maine Osteopathic Association (where he is serving on the Board of Directors), the National Board of Osteopathic Medical Examiners Board of Directors and the American College of Osteopathic Family Physicians.

Dr. Buser received the Outstanding Faculty Member Award at UNECOM in 1987 and the UNECOM Teacher of the Year Award in 1988.

Educator of the Year recipients are selected by one of the nation's colleges of osteopathic medicine (on a rotating basis), in conjunction with the NOF Osteopathic Progress Fund/Seals Committee made up of osteopathic physicians, osteopathic educators and AOA representatives. The program has been recognizing Educators of the Year since 1983.

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

Perceptions of Osteopathic Women Physician Leaders: Current Status and Future Directions

Isabelle A. Chapello, DO, FAAO

A Story About Perception

A little boy standing by his mother saw a dog, pulled away from his mother three separate times and appeared to study something intently. His mother inquired why he was doing this. He explained that the dog looked very bad in the face. He was looking at an English bulldog. To him, dogs should have a long nose, not the pushed-in muzzle of a bulldog. The bulldog did not fit his perception of what a dog should look like.

Introduction

In the history of civilization, women in their successes have challenged a status quo that served only half the population in a double standard world. The answer to the question where a battle of the sexes exists today can be found in the interpretation of women's achievements and independence. Are they perceived as successes or threats in a male dominated society? Rather than a battle, let us work together to multiply our collective leadership strength with toleration and good humor.

What are the ultimate goals of women leaders in the American Academy of Osteopathy (AAO) and in the osteopathic profession? Several main directions surface: 1) to disseminate ideas about osteopathic manipulation, 2) to publicly communicate osteopathic medicine to the general population, 3) to remain ever vigilant and 4) to demonstrate courage in defending our convictions. Although these directions seem intangible, several concrete steps may be taken. For instance, we may channel our efforts in disseminating ideas about osteopathic manipulation through increasing visibility in local osteopathic component societies, state associations and the American Osteopathic Association.

Similarly, we can increase visibility in the public sector by membership on local county boards such as mental health, public health, schools and boards of commissioners. Likewise, we need to remain ever vigilant by increasing our visibility through nurturing acquaintances with current state and federal representatives and senators. With this increased visibility comes the need for courage to defend convictions strategically and professionally. To accomplish these goals requires leadership.

A Brief Sketch on the History of Women in Osteopathic Medicine

The influence of women in our profession has had a long history. In the beginning of osteopathy, women were in the ranks of providers. A.T. Still espoused women's rights; 21 students of his first class in 1892 included 5 women. Five years later, a class of 500 included 100 women. An early leader, Jeanette Bowles, became the first female faculty member of the School of Osteopathy in Kirksville, Missouri, in 1983. Later, she founded a school of osteopathy in Denver. Additionally, she was the first editor of the *Journal of Osteopathy* and a first vice-president of the American Osteopathic Association (AOA).

In 1908, 566 women were among the 1595 members of the AOA. From this promising start, the opportunities for women in the profession began to change for the worse. Female enrollment in schools of osteopathy declined in the early twentieth century. This trend continued through the sixties, and by 1971, only three percent of the graduating classes of schools of osteopathy were female. In the past 20 years, however, the number of women entering schools of osteopathy has risen.

Now, as our numbers increase, we as osteopathic women physicians need to act with resilience and responsibility in influencing medicine. This need, however, must be guided by research. Presently, few women have leadership roles in the profession; the age range from 45 to 54 represents only 6 percent of female

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DOs. As such, we presently have only a small base of female leadership. This situation is likely to improve in the future as a majority of females within the profession are currently under the age of 35 (51 percent). Of these, a substantial number (46 percent) are still enrolled in schools of osteopathy, and hence, have yet to assume a leadership role. Still, our current pool of female leaders can offer us much in terms of guidance during the transition to greater leadership involvement.

To date, few studies have examined issues of female leadership within the profession. Studies that have been conducted usually present summary statistics of leadership roles by gender but tend to overlook female leaders as resources in decision-making. As such, a gap exists in our understanding of the guidance these women leaders can provide. This study is offered as a beginning in the examination of the views of women leaders regarding their role in the American Academy of Osteopathy (AAO) and the osteopathic profession. With this objective in mind, I have asked the following research questions.

1) What is the current status of the leadership of women physicians in the AAO and the American Osteopathic Association (AOA)?
2) What do women leaders perceive as appropriate avenues of change within the associations to assist other women in advancing their professional status?
3) What do women leaders perceive as future directions for the leadership role of professional women?

a) What are the needs of women in attaining future leadership roles?

b) What are the means of attaining advancement within the professional organizations?

Design of Study

The Sample

All women in the profession are leaders, but I do not possess the capability of interpreting large numbers of responses. Although large scale surveys are possible, the use of summary statistics often obliterates the personal understandings and more unique perspectives of respondents to these surveys. In an effort to retain the flavor of individual responses and the private meanings informants have, I have decided that a smaller-scale survey is more appropriate. Therefore, a small group of females was chosen representing a broad spectrum of specialties, positions held, geographic areas and age ranges.

Table 1
Leadership Roles by Physician Informant

Leadership Category	1	2	3	4	5	6	7	8	9	10	11	12
AOA Board of Trustees		*		*					*			
AAO President								*				
University Professor	*	*		*				*	*		*	
Chief of Hospital Staff		*	*									*
Female Surgeon											*	
President State Osteopathic Assn	*	*	*		*	*			*			
Obstetrician						*						
Instructor Osteopathic Manipulation	*			*	*	*		*				
Cranial	*			*	*	*		*				*
Other			*	*	*	*		*				
Years in Practice	9.5	36	27	15	30	10	18	12	35	42	8	28
Certification	GP OMM	GP	GP BA	OMM CA	OMM	OB/G OMM	OMM	OMM CA	IM	FAAO	ACS	GP

GP = General Practice; OMM = Osteopathic Manipulative Medicine; BA = Bariatric; CA = The Cranial Academy;
OB/G = OB/Gyn Surgery; IM = Internal Medicine; FAAO = Fellow of the American Academy of Osteopathy
ACS = American College of Surgeons

Osteopathic physician informants of the survey were selected on the basis of having achieved positions of leadership within the AOA or AAO. Selection was also made for individuals engaged in the following activities: professorship, instructor of osteopathic manipulative medicine, chief of staff, surgeon, obstetrician, internist or state osteopathic association president. This yielded a pool of 14 informants who received the survey instrument. Of these, 12 returned completed questionnaires. Table 1 shows the positions held, and professional leadership roles of the informants who returned their questionnaires. In addition, Table 1 shows the years of experience in medical practice and the certifications held by each of the informants.

The Survey Instrument

The survey instrument consisted of 22 questions primarily derived from articles by Mandelbaum-Schmid (1992) and Baker (1991). Several questions were based on observations of current trends. Largely, questions were of the short-answer, essay variety, although two multi-faceted questions asked the respondents to rate their perceptions on various issues. One of these questions asked the respondent to rate how females DOs are perceived as a group. The other question asked the respondents to rate their perception of health-related social issues.

The survey questions dealt with several areas of possible concern to female leaders. The areas of focus were a) the art of communications (questions 104), b) perception and future of female DOs (questions 5-7), c) heath care (questions 8-12 and 19), d) societal concerns (questions 13-15 and 22) and e) leadership issues (questions 16-18, 20-21).

Analysis of Data

The data was analyzed using a phenomenological approach.[2] This approach facilitates the distillation of the informant's responses into themes while preserving particularly expressive insights. For the purposes of analyzing the data, each respondent was assigned a number. Analysis proceeded question by question by constructing a response table for each question. As can be seen in Table 2, each data table consisted of three columns. The columns recorded the informant's number, response summary and quote. Summaries of each individual's response to a particular question were derived by capturing the essence of the response to construct a synopsis or reduced version of the response. As these were gathered, themes emerged within each question. Question themes were then used to construct commonalities within each issue domain. These common themes are described in the following section. Particularly powerful statements were recorded as direct quotes which could be retrieved later in discussing the data. Thus, I tried to retain the intent of the leaders' responses in constructing the discussion of the results. This is in keeping with the phenomenological tradition of research which seeks to understand the viewpoints of others as they see them rather than as we see them.

Concerns About Communication

Within the area of communication, four questions were asked. The first of these questions centered on making medicine more humane. To accomplish this, respondents favored applying the "Golden Rule" to patients, peers, students and strangers and to pass on the ideals of compassion to osteopathic medical students through teaching and through example "by providing a role model of a physician who is communicating with a person who has a name instead of a case of a disease". One respondent, concerned with developing compassion in medical practice, stated quite eloquently that we should "be able to cry with our patients". As for the needs of female medical students and those preparing for specialties, respondents felt provisions such as flexible schedules and help with child care support female colleagues and recognize their needs. Additionally, women DOs need to speak up about male cultural traditions within medicine that are not conducive to learning such as "24 to 36-hour shifts". This respondent felt that a partial solution may be to reduce residency loads for deserving female and male residents.

Second, prior to effective communication with all DOs, there surfaces a need for us to be more effective communicators. This may be accomplished through instruction, newsletter dialogue for female DOs, whether quarterly, undergraduate or post-graduate and a column for women DOs in our DO magazine. Others felt that the importance of communication should be recognized. We can begin to accomplish this goal through continuous training in listening and conflict resolution and working in cluster groups that provide intellectual interaction. In addition, one leader felt that a change of attitude and thinking about the other person was in order by being considerate of another's life situation. Although recognition of differences in male and female styles of communication were noted, still, disagreement appears to equate with dislike. To cope in weathering disagreement, increased self-esteem can be touted

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Table 2
Typical Data Table (survey question 1)

Inf.#	Response Summary	Quotes
1	- teach compassion	"Be able to cry with our patients"
2	- golden rule	"...patients, peers, students, strangers"
3	- teach & guide students - government reduce malpractice insurance	
4	- male cultural traditions adversely affects learning	"Push for pregnancy leave, reduced-load residencies for deserving females and males etc."
5	- golden rule	
6	- support female colleagues: flexible schedules and child care - develop support mechanism for female DOs in post-graduate training	
7		"Be the best we can be as women, not trying to imitate the male physician."
8	- be directly involved with students - Need recognition for the teaching of humane skills	"To become involved in the teaching of humane skills to our students and in rewarding such endeavors with honors and position."
9	golden rule	
10		"By providing the role model of a physician which is communicating with a person who has a name instead of a case of a disease."
11	- personal care to patients and families - passing on ideals thru teaching and example	
12	golden rule	

individually and collectively for women physicians while male physicians can also fall back on already engendered self-esteem.

Third, refinement of communication skills was seen as necessary by means of a) more instruction, b) audio tape self-analysis, c) speaking the same language, d) professional dress and manner, e) networking, f) changing attitudes toward our clinical preceptors, g) treating students as physicians to help them assume the role and h) intellectual interaction. Although extemporaneous speaking is undoubtedly more focused upon the listeners, speaking up in a considerate manner when opportunities present themselves is paramount to leadership. "Good luck" was mentioned in accomplishing an improvement in this area.

Fourth, concerning communication in regards to membership, there was agreement that the settling of important issues prior to a meeting is denigrating. It is all right for routine matters and agenda setting, but for other issues, it depends upon who settles them and whether all parties are represented. Along these lines, one leader stated quite succinctly,

> "Not only is the activity counterproductive, but it also destroys the minority opinion from being expressed. We must remember that all great change begins with a minority of one, i.e., A.T. Still; and all great calamities begin when a power group usurps the rights of others, i.e., WWII."

Perception and Future of Women DOs

When the future trend of women in osteopathic medicine was examined, all respondents agreed the proportion would increase to around 50 percent and may plateau there depending upon

the rate of advancement of women into leadership roles. Another thought that future increases in the proportion of female DOs may accompany the removal of financial incentives. Moreover, this trend may be predicated on the flexibility of society in accepting "part-time" leaders, that is, women who must split their time between the activities of daily living and their professional roles. One telling response was, "In medicine, women must be clinicians and administrators, while men can be administrators alone and garner handsome paychecks". The issue of inequity of pay between male and female physicians for services rendered seemed to recur in one other response to this questions. It stated,

> "Most (women) will tend to go into primary care or lower paying jobs. This low paying practice must stop! Women should be paid the same as men. Primary care is as important as, or perhaps more valuable than, the specialist."

When asked about the future of women in leadership in professional organizations and the congruency between role, income and status, responses were rather negative. For example, one put it this way, "Leadership roles for women stink. Women have to fight to get equal monies." Another said, "Still, some females may slow track to spend time with their families so the number in higher positions by choice will not represent the number who are qualified." However, one saw the issue as a matter of individual choice. She stated, "The role women have in leadership depends on the individual. Some women have no interest in leadership. I think there is a trend for more women to step forward and voice their opinions." This trend is occurring in spite of some men viewing women in positions of leadership as threatening to their control or power. However, this situation may not be uniform among professional organizations; one leader sees differences in leadership structure restricting the percent of female DO leaders such that their numbers are likely to remain status quo until the board membership of some professional organizations changes.

Another linked the future of women's income and status to current management practices in the health care field. She stated,

> "Increasingly poor compensation for time and effort in practice. Management companies want volumes of patients to be cared for...Non-physicians are managing the business of medicine. The insurance folks are gatekeepers not doctors. It is expensive to go to medical school and expensive to pay insurance for the privilege of being a public servant."

From this quote, I can infer that this further stretches the same health care dollar to pay for the administrator who has been placed between the physician and the patient. Therefore, there will be fewer health care dollars filtering down for those who need them. One leader echoed this position by stating that in the future, most physicians will be employees of large government third-party payor controlled groups.

When asked to contrast the perceptions of male and female DOs, the respondents tended to believe the following (see Table 3). As shown in Table 3, these respondents perceive women DOs as more empathetic, spending more time with the patient and being naturally able performers in general practice, OB/Gyn, pediatrics and OMT. One added geriatrics and common sense, while another added internal medicine, psychiatry and rehabilitation. At the same time, they are mostly viewed as being less authoritative, are less motivated by money, practice fewer hours per week and have less earning power. However, one respondent believed women to be equally authoritative, less than equal in earning power and able to perform equally in all health care areas except orthopedic surgery.

Health Care

The response to whether the methods in the health related agencies such as the FDA, Medicare, Medicaid and OSHA are helpful to patient care varied from being helpful to "it stinks". The least positive of the responses viewed the agencies as being unrealistic for OSHA, a necessary evil in the case of Medicare and mandatory for the poor with Medicaid. Another leader thought that these agencies have lost sight of their original purpose. She stated, "We have empowered a system, not the people that these agencies were charged to care for." However, several others thought these agencies, although possibly helpful, are over-regulated. One said, "They've all gone overboard in rules and regulations; some (are) actually against the constitution's rights to individuals." Furthermore, they felt that these government interventions cause increased paperwork and expense.

The opinions regarding the usefulness of epidemiology as a measurement tool were split between those who thought it has been over-rated and those who have no opinion. Three felt it adds to the rest of the available information, while another felt that, from the osteopathic standpoint, an appropriate balance between health and disease must be sought.

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From the AOBSPOMM Files

AAO Case Study

"Sinusitis"

by Karen E. Sept, DO, CSP-OMM

Editor's Note: *Karen E. Sept, DO, certified by the American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine, earned the Cranial Academy Certificate of Competency and is a Diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons. She presently is in private practice specializing in osteopathic manipulative medicine.*

Identification

S.M. is a nine-year-old white male.

Chief Complaint

He presented with the complaint of constant purulent sinus drainage over the last year which had been treated with multiple courses of antibiotics and decongestants. He also had a history of migraine headaches. He was seen by pediatric neurologist, and a MRI and EEG were both found to be normal. His headaches were found to be triggered by chocolate; eliminating chocolate from his diet decreased his headaches to only once a month. His mother thought he might also be allergic to cheese. He had no other history of atopia and history of eczema or asthma.

Past Medical History

Negative

Past Surgical History

Negative

Birth History

No difficulties. Labor was six hours total.

Trauma History

Patient has not been involved in any motor vehicle accidents. He fell out of a tree, landing on his back, just a few weeks ago. He had many injuries to the head which required suturing. He has had lacerations on his left eye, occiput and twice on his chin which required sutures.

Medications

None

Allergies

None

Diet History

Mother described him as a very picky eater for the last two years. He would not eat anything red in color.

Breakfast:
Kix cereal with milk

Mid morning snack:
Kix cereal with milk

Lunch: Often no lunch, occasionally soup or macaroni and cheese

Mid-afternoon snack:
Chex cereal with milk or jello

Dinner: Hot dogs with ketchup, occasionally baked potato or cooked vegetable

Physical Examination

Weight: 28.8 Kilograms
Temperature: 98.1 Fahrenheit
Pulse: 78
Respiration: 18

This well developed, well nourished nine-year-old boy was in no acute distress. He was very talkative, friendly and cooperative. Physical exam was significant only for ENT exam. Tympanic membranes were pink and mobile. Inferior turbinates were red with purulent exudate. Face was non-tender. Posterior oral pharynx was clear. Neck was supple and without lymph adenopathy. On structural examination in the standing position: Right ear was inferior, right shoulder and tip of the scapula were superior, right iliac crest was inferior, greater trochanters were equal. Lateral curvature was noted in the thoracic spine with a convexity right and apex at T8. His ear was noted to be anterior to the line of gravity. There was a notable flattening of the thoracic spine. Standing and seated flexion tests were positive on the right. In the supine position the pubic symphysis and anterior superior iliac spine were inferior on the right. In the prone position he was noted to have a left on left sacral torsion. The sacrum was markedly extended. On cranial exam his sphenobasilar symphysis was compressed. There was both an inferior vertical strain and a left torsion pattern.

Initial Assessment

1. Somatic dysfunction all areas
2. Mild scoliosis

(Consideration should be given to a short leg syndrome.)

3. Chronic sinusitis by history
4. Migraine cephalgia

Initial Treatment Plan

I initially planned for a program of weekly osteopathic manipulation. I wanted to treat him two to three times addressing the pelvic and lumbosacral areas of dysfunction before obtaining a postural X-ray study for an anatomical short leg. My reasoning for waiting on the X-rays was if the asymmetry resolved with manipulation alone, then certainly he had a functional short leg, but it would not be necessary to subject him to the radiation required to assess an anatomical short leg. I planned a treatment program to include all areas. First treating the pelvis, lumbar, sacral and lower extremity areas; then a venous sinus technique; the third visit would address his diaphragm, lymphatic drainage and thoracic spine. On the fourth visit, I planned to treat his cervical region and the base of the skull. On the fifth visit, I would address his vault and orbits, and the last treatment would involve intraoral techniques for the face.

We discussed the importance of a healthy diet. Since he was old enough to be involved, I directed the responsibility of dietary change to him. He was to start by including at least one piece of fresh fruit in his diet a day and discontinue all milk products.

I wanted him to start a stretching program such as hatha yoga to gain flexibility throughout his entire spine. This was especially important because of the scoliosis that had started.

I also planned to introduce some measures to promote good sinus drainage, such as nasal irrigation, stimulating Chapman's reflexes for the sinus and lemon juice in tepid water every morning. These measures would be introduced slowly over the next six weeks so as not to overload him in the beginning.

Course of Therapy

As planned, the first treatment was aimed at normalizing the pelvis utilizing muscle energy techniques. At the conclusion of the first treatment, his ears were equal, the right shoulder was elevated, the tip of the scapulae was equal, the iliac crest heights were equal and there was only a slight lateral curve with the convexity right still present in the thoracic spine. This improvement was still present at the next treatment. At the second treatment I used the percussion hammer to his lower extremities, in addition to addressing the thoracic spine. The following visit he had symptoms of an upper respiratory infection with purulent exudate noted from the right nare. He was treated with osteopathic manipulation utilizing techniques to stimulate sinus drainage and encouraged to drink more fluids and use steam in halation to thin the nasal secretions. This episode cleared without antibiotics and the following week his inferior turbinates were noted to be pink without swelling or purulent exudate. He had one more episode of nasal congestion and cough approximately five weeks later. However, he had no fever or chills and had a good appetite. He said he did not feel sick. He had quit doing his exercises and sinus irrigations. His vitality was low. His thoracic inlet was quite restricted. Sinus X-rays were obtained because I suspected a sinusitis. The left maxillary sinus was indeed cloudy. After discussing all the options with his mother, we chose to institute measures to encourage sinus drainage without medications. I instructed them to follow up the following week, or sooner if his condition worsened. At that time he was much better. The treatment program was completed. He was encouraged to continue his home program of diet, exercises and preventative sinus measures. He was seen in follow up six weeks later and had continued to do well.

Discussion

Sinusitis is probably one of the best examples of the importance of mobility and the consequences of stasis. Simplistically speaking, sinus infections occur because of stasis. It is with that stasis that the set up for infection occurs. Restoring motion of the cranial bones, thinning the secretions with increased fluid intake and steam, normalizing the autonomics to the sinuses which control the secretory mechanism and circulation and assuring mobility of the cervical spine for drainage will help eliminate the mechanism for infection. Of course, many other factors also play a role, such as diet, exercise, rest and a smoke-free environment. Antibiotics will eventually eradicate the organism once they reach the sinus mucosa but will not help the sinuses to drain, so consequently without good drainage, the set up for infection still exists. Osteopathic manipulation is a most important modality because it can promote drainage by restoring mobility. ❑

From the Archives

Management of the Cervical Area

by J.S. Denslow, DO

A paper which deals with the cervical area must take into consideration the different anatomical and physiological aspects of the sections involved.

Because the organs of special sense are located in the cranium, it is necessary that the cervical section of the vertebral column be highly mobile. As a result, the typical cervical vertebra is designed to permit a wide range of flexion and extension, rotation and lateral flexion. In addition, there are two highly specialized joints. The first, the atlanto-occipital articulation, provides almost pure flexion extension while the second, the atlanto-axial articulation, has almost pure rotation.

An additional anatomical fact is that the bodies of the vertebrae in the cervical area have lateral lips which project upward on the superior aspect and an anterior lip which projects downward at the anterior margin. This provides a stabilization which is unnecessary in the other spinal areas where the anterior and lateral body walls are both large and strong.

Since osteopathic lesion pathology involves both positional and mobility characteristics, it is essential that the normal direction and range of motion be thoroughly understood.

Typical Cervical Joints

In the typical cervical articulations the articular facets are at an approximate 45 degree angle with the top and bottom of the vertebral bodies. Being in this plane, it is apparent that rotation and lateral flexion must be complimentary movements. For example, if the third cervical vertebral is moved forward on the right, it must also go upward on the right.

At the atlanto-occipital articulation, the facet planes, although concavo-convex from front to back and from side to side are not approximately the same plane as the top and bottom of the bodies of the other cervical vertebrae. This provides almost pure flexion and extension. However, as the anterior arch of the atlas is approximately half the range of the posterior arch, the two articular surfaces are not in parallel; instead, when the arc created by each articulation is projected backward the two roughly form a flat circle. Hence, there is a slight amount of rotation. As will be seen later, it is our opinion that this slight amount of rotation is almost always involved in lesions in this area.

The plane of the atlanto-axial articulation is similar to that of the one immediately above. However, the facet surfaces are nearly flat. The dens which projects upward and which articulates with the posterior surface of the anterior arch of the atlas prohibits any major movement except rotation.

Structural Landmarks

A diagnosis of the positional arrangement of the cervical vertebrae must be made on the basis of palpation of the bony prominences. In a typical cervical joint, those which are of more value are the articular processes. They lie approximately one-third of the distance between the tips of the spinous processes and the tips of the transverse processes. The are the most accurate information concerning position. The spinous processes are bifid and extremely irregular. The transverse processes are divided into anterior and posterior tubercles, and there is no way of predicting which of the tubercles is largest. Hence, neither the transverse processes nor the spinous processes can be depended upon to yield accurate information.

As the lower half of the second cervical vertebrae has the characteristics of the typical cervical segments, its articular processes may be used in diagnosis.

In dealing with the atlas, the lateral portions of the posterior arch are accessible to palpation and are reasonably symmetrical. The transverse processes may also be palpated in the space between the mandible and the mastoid processes.

Common Lesions

Immobilization may occur in any one of the movement planes of the joint. Likewise, lesions may occur at any stage of a given movement plane. Consequently, it is impossible to dogmatize as regards the "types" of lesions which may exist. They are as myriad as the joints are complex. Hence, it is indicated in a short discussion of this type that the common lesion pictures be considered.

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In the typical cervical joints there are two common positional disturbances. The first is one in which a given vertebral segment rotates backward and lateral flexes downward, both movements occurring on the same side. This is spoken of as a "typical posterior lesion". The other is a condition where a given segment rotates forward and lateral flexes upward, both on the same side. This is spoken of as a "typical anterior cervical lesion".

Although cervical lesions in our experiences are predominantly unilateral, both of these lesions may be found in a given joint as a bilateral disturbance.

The inferior half of the axis is typically cervical in its characteristics, and hence follows the pattern of the balance of the area. The customary manner of describing lesions is to name the upper of the two bones involved, and disturbances between the atlas and axis will be considered as atlas lesions. The common lesion of the atlas (in its relation to the axis) is one of rotation in which the atlas moves backward or forward on the axis. If it moves backward on one side and forward on the other, it is a bilateral lesion.

Lesions between the occiput and the atlas are considered as occipital lesions. It will be recalled that while the major motion between these two structures is flexion and extension, the placement of facets is such that a slight amount of rotation can occur. It is our opinion that these rotations constitute the most common lesions of this joint.

Treatment

Any technic which is designed to apply force to carry the segments of the involved joints toward the normal position and range of motion may be used. Several typical procedures will be demonstrated.❑

Paradoxes Discovered by an Octagenarian

by Irvin M. Korr

The less concerned I am about what is right and wrong for others, the more certain I become about what is right for me.

The less I care about "what will people think"—about me, what I say and what I do —the more I care about people.

The less I defend my words, my deeds and myself, the less the need for defense.

The more I choose to be bound by the laws of nature, the freer I become.

The more I remain me, the more I change; the more I change, the more I become me.

The more I learn, the less I have to remember. The less the need to remember, the larger the space for learning.

The less distinct the boundary between me and the rest of the universe, the more distinct is my identity.

The walls that surround us in our minds, and within which we have been taught to live, are as constraining as the tallest and strongest of stone walls. Yet they crumble and vanish when we walk through them.

That which is spurned as chaff by others is often grist for my mill.

The sharper my view of now, the farther I can see ahead.

To "get our of the woods", I first go into the woods.

The more nearly that "time runs out", the less hurried I am.

The more whole I become, the better my parts operate.

My body always strives to meet my expectations of it —good or bad.

I shall be most concerned when I cease to be concerned.

Enlightenment comes on its own, and unexpectedly, when I cease to pursue it.

The higher the fence I erect to exclude others, the more I am their prisoner.

I have sought to live in such a way that I can expect to die young —when I am very old.

continued from page 13

the underpinning of which is to take advantage of the assumption that specifically placed harmonic oscillations assist traumatized and rigid tissues to move into homeostasis. Far fetched? The reverse is common knowledge, that is, deleterious oscillation is related to low back pain in patients who, for example, work as truck drivers or jack-hammer operators. Note the power of harmonized wind-producing gross move-ment in a suspension bridge that would not similarly move under the weight of a multitude of cars. We can benefit from guiding physicists looking into the possibility of skull bone movement harmonized in relation to the CRI.

The author suggests the key to research across disciplines is the degree to which we clarify natural law in regard to our clinical approach.

Even the casual reader may realize that the literature on the CRI and that of headache has been converging. This is the natural order of things, since intelligent professionals are working with the same problem in the same set of organisms. Yet, this convergence perhaps has been hampered by a number of factors, not the least of which follow.

First, some information can tend to be locked within disciplines. For example, neuroanatomy research may arise from having read information mentioned in passing in a neurophysiology journal,[52] yet trying to find this unkeyed information in a literature search would tend to keep the knowledge locked within disciplines. Language barriers also exist to hamper critical review of untranslated, nonabstracted text.[20]

Second, phenomena may be missed as clinical attention is focused elsewhere.[47]

Third, there may be no prior exposure to crucial ideas and techniques which can give rise to cooperative research; this needs to be remedied by institutional and personal effort at mass education.[48,49,50]

"... the search for appropriate and cost effective patient care should neither be hampered nor advanced on the basis of exclusion but rather on cooperation between professionals educating each other out of respect for the patient."

Fourth, there tends to be a de-emphasis in the literature on personal powers of observation in favor of what can be measured by technology, compounded by the notion that the literature is ahead of what we know.[51] In many cases, such as work with an electron microscope, this line of reasoning is good. In other cases, like the discovery of the digitalis leaf, or acupuncture, declining study because of unsubstantiated case reports, or the notion that "not a shred of evidence exists to date in the literature to support case report claims" would have been an unproductive way to proceed.

Look at the work of turn of the century Nobel prize winner Santiago Ramon y Cajal who utilized his powers of observation to describe the histology of the nervous system. Reliance on technology and current literature could not replace simply looking carefully at his original work to catch up with his old observations.[52]

Similarly, a final factor to be considered arises in a quote from Still's preface to his *Philosophy of Osteopathy*[87] on how his ideas might be viewed by his colleagues: "I do not expect it to meet their approval; such a thing would be unnatural and impossible."

The reader may recall instances in his/her own experience witnessing doctors of any profession protecting their intellectual turf or glorifying themselves at the expense of others. This behavior[36,44] tends to reinforce the notion that the world is indeed flat.

If anything can be learned from this article, the search for appropriate and cost effective patient care should neither be hampered nor advanced on the basis of exclusion but rather on cooperation between professionals educating each other out of respect for the patient.

Let us suppose for the moment that we can align the big picture on how we have been approaching the CRI, headache and medicine in general. One might argue that patients have been doing just fine with the drug/surgical approach for years (and in the area of infectious disease for example, in the author's view, such reasoning has merit with respect paid to pre-antibiotic and adjunctive manipulative techniques).

Similarly, if you were a patient dying after being run over by a car and being helicoptered to a trauma unit, your thoughts might prioritize

on an allopathic or osteopathic trauma surgeon willing to operate first and manipulate later. The point is informed physicians know not all approaches to health are effective in action the same way at the same time. Also, in fairness, a discussion of the drug approach is incomplete without mentioning that significant research is associated with this approach.

On the other hand, there are significant costs and side effects associated with the use of these types of treatments on a scale which absolutely pales into comparison with any conceivable side effects reported to date associated with the widespread use of Sutherland's techniques. Similarly, there are significant research costs undertaken by major government and private interests. Medical faculty interested in research have turned to private sources, particularly, the pharmaceutical industry for support. Consideration of the risk/benefit ratio and economics are among the factors which guide the drug approval and wide drug dissemination process in this country. In one study 89 percent of published research was funded by the government (79%) or the pharmaceutical companies (10%).[85]

Okay, what about giving in to the notion that drug use is popular because patients overwhelmingly prefer taking a pill? Perhaps unconventional (non-drug/non-surgical) approaches to medical research are not what the patients deserve in this time of diminishing resources. For what it is worth to you, the United States Congress[17] and the patients do not seem to agree. There has been a general feeling out there for years that in a significant number of cases the conventional approach to chronic ailments is lacking. Perhaps a lot of physicians are not aware of this because patients are not telling their conventional doctors about their feelings. The reader is referred to the *New England Journal of Medicine* to formulate an opinion on a view of what is conventional and unconventional.[16]

The time has come for aligning our approach to understanding common problems together. The pooling of resources and the casting away of prejudice[79] in favor of mutual education is the approach which will ultimately benefit the patient. There is not a physician or scientist, regardless of his/her interests, that does not stop and give thanks when a body process is clarified in a discovery which improves patient care. The highest reality is establishing a correct diagnosis and utilizing the treatment which does comparatively the most good with the least harm; that, and not your particular orientation, is what benefits the patient.

"The time has come for aligning our approach to understanding common problems together."

In that spirit we should be pooling our expertise to capitalize on what is best for the patient. The possibility of disseminating widely a further understanding of a generally unfamiliar, yet basic phenomena, the risk/benefit ratio and economics demands a cooperative look into the CRI. Suggestions on how to proceed follow.

The first suggestion is to gather experts across disciplines to cooperatively look into the basic assumptions of the cranial rhythmic impulse and constructively advance our knowledge. This effort is now underway. This paper was underway before and now is the author's contribution to those of us gathering to direct future efforts.[18]

The author suggests consideration of the following lines of research (among others very possibly preferable) to clarify the basic assumptions, bearing in mind until comments below that this effort is apart from consideration of successful clinical outcomes associated with Sutherland's approach to the CRI.

With regard to skull bones moving, research topics include the following:

1. Agreement on the structural extent and integrity of bone bounding tissues within sutures
2. Agreement on the basic functional nature of tissues within sutures
3. The degree of ossification of the internal table of bone at various suture lines and the effect on cranial motion
4. Agreement on which sutures are ossified and when

With regard to certain cranial and peripheral substances moving in rhythms research topics include the following:

1. Use of imaging techniques to visualize cerebral blood flow in real time relation to cerebral spinal fluid flow

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2. Agreement on the nature and forces behind cell and substance oscillations centrally and peripherally

With regard to palpatory sense revealing central and peripheral movement, research topics include the following:

1. Agreement on the smallest movement which can be palpated in relation to the degree of internal and external cranial movement

2. Clarify the role of magnetism on palpatory sense, between patient, clinician, environment. tissue and vascular fluid

3. Establish the effect of polarity[30] (net tissue charge varied by anatomic location) on palpating various locations in the body. The reader may wish to try alternatively and gently palpating the pectorals of a patient with different fingers, on different hands, on different sides of the body and note any difference in the feel of the tissues

Lastly, the author proposes further study into a fourth basic assumption, namely:

1. The application of palpatory sense utilizing Sutherland's techniques makes use of central and peripheral movement to influence processes for beneficial clinical outcome. (In other words, what we do clinically works because of what we think we are doing and not through some other mechanism.)

2. Clarification of the effect of palpating external head and body tissues setting up a peripheral response rather than a direct central response

3. Determination the effect of treatment on the neural and endocrine axes with particular attention paid to the hypothalamic-pituitary axis

4. Clarification of the anatomy and alternative function of structures which pass from outside the skull through the skull. For example, what role do the emissary veins[83] play in altering cerebral blood flow into meningeal circulation before, during and after tension headache? Do Sutherland's techniques indirectly effect meningeal blood flow in this fashion? Does relaxing scalp tissues alter meningeal blood flow directly or indirectly? Is there a homologous functional relationship between the sinovertebral nerve supplying the posterior longitudinal ligament and intervertebral disc spaces[9] and possible innervation of the dura and spaces between sutures?

5. Separation of patient outcome studies from the need to clarify mechanism of action (helpful drugs are in use everyday, with mechanism of action unknown)

Let us pool our resources across disciplines and teach each other what we do and do not know for the benefit of the patient. Cooperative research that has an appropriate design to actually study what we are doing and feeling is the direction we should be headed. There is mystery between the phenomena of a treatment working and how a treatment works or for that matter how a treatment feels.

To professionals willing to be educated and progress, the goal for designing cost-effective, appropriate patient care is not only getting enough educated interested people of goodwill with the means to search for answers, but also, to accept them for the benefit of the patient. Finally, knowing where and how to look for answers is the key to seeing what remains to be seen.

Conclusion

We owe a tremendous debt to our predecessors who have educated us to care for the patient in accordance with natural and human law. In this time of re-assessing human laws governing health care, let us look to natural law to help us define to our colleagues and government a cost-effective, appropriate form of health care for promotion. The laws of nature are complex, and a cooperative effort of unbiased professionals across disciplines is needed. This paper has been written to assist in that effort. The author looks forward to learning further about what is and is not known. This is done out of respect for the patient and our colleagues, who seek to build bridges of knowledge and understanding across boundaries to caring about each other.❑

(References available from the Academy office upon request)

Letter to A. T. Still

Dear Doctor Still,

The other day I was talking with a friend of mine, and we were discussing some of the commonly used terminology that we physicians take for granted. For example, we commonly speak of the "art of medicine". We also think of medicine as a science. In addition, we DOs like to refer to the philosophy, principles and practices" of osteopathic medicine. My friend and I were wondering just how to define some of these terms. What is the art of medicine? Where does the art of medicine leave off and the science begin? Is one's philosophy based on principles, or are one's principles based on philosophy?

One of your students, G. D. Hulett, wrote a book entitled *The Principles of Osteopathy*. I have been told by some that his work most closely adheres to your actual teachings, so I thought I would investigate what he had to say about all of this. On page 11 of his book Doctor Hulett wrote, "Dr. Still mentions the fact that while yet a boy, a case of headache was aborted resting his suboccipital region with a rope swing. That was the art of osteopathy. Similar cases and observation of other facts accumulated until an inkling was obtained of a law underlying the several facts. The recognition of that law and the application of it to still further cases constituted the beginning of the science. The facts continually accumulating, with few exceptions that could not be explained, and their systematization, justified the presentation of a **working hypothesis**. It is the discussion of this hypothesis and the facts substantiating it, the taking it as far as may be from the realm of theory into the realm of demonstration, that constitutes the principles of osteopathy. The application of the principles to specific cases of disease constitutes the practice of osteopathy."

To this day we still have trouble articulating exactly what we mean by "osteopathic principles and practices". These kinds of discussions may go on forever, but I feel that it is helpful to consult writings like yours and Doctor Hulett's to guide us in our understanding.

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

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As for women DOs' ability to influence women's health issues, all felt that we can if we want to spend time on these issues. We can lobby or influence women's health issues through the media, but it takes money to do these things. One thought that as a group, "We are perceived as authoritative and female, so that if we speak out, we represent two groups simultaneously" (those being professionals and women). Another said, "We also tend to look for rhyme and rhythm in care and are more likely to go with gut feelings." However, one leader who felt that we can influence any health issues by speaking or by writing thought that, although women's health issues are important, they should not be advanced through adversarial means "by getting off the soapbox of women versus men physicians and turn attention outward to the needs of the patient."

When asked about the importance of prevention and the need for patient effort, respondents tended to feel that prevention is often neglected for several reasons including our preoccupation with fighting disease, the lack of time to teach prevention to the patient, its lack of glamour and its financial unprofitability. One stated, "Patients do not want to pay for *any* type of health care since they expect insurance to pay. Insurance companies do not want to pay for anything, least of all prevention." For the insurance companies, it is a numbers game. They believe that fewer will become ill and cost less than prevention for the masses with its long-term potential benefits. One respondent thought prevention involves manipulative osteopathy from birth onward. A compelling statement was given by another respondent who said, "Instead of always preventing something, perhaps we should focus on control."

This particularly keen observation leads me to the following thoughts. As a society, we are in the "instant"

Table 3
Perceptions of Female DOs as Compared to Male DOs

Inf# Issue Category

	1	2	3	4	5	6	7	8	9	10
1	M	L	L	M	=	L	M	L	M	GP, OB/Gyn, Pediatrics
2	M	=	L	M	NR	L/=	=	=	M	All except Orthopedics
3	M	L	L	M	M	L	L	M	M	Geriatrics, OB/Gyn, Pediatrics
4	M	L	L	M	L	L	M	L	NR	OB/Gyn, Pediatrics, FP, OMM
5	M	L	L	M	L	L	L	L	M	OB/Gyn, Pediatrics maybe
6	=	L	L	M	?	M	M	M	M	FMed vs GP, OMM
7	M	L	L	M	L	L	M	L	NR	Pediatrics, GP
8	M	L	L	M	L	L	M	M	M	OB/Gyn, Peds/GP/IM Psychiatry, OMM, Rehab
9	M	L	L	M	L	L	?	L/I	L	Pediatriacs, OB/Gyn
10	M	L	L	M	L	L	M	L	NR	Gp, Pediatrics, Ob/Gyn
11	M	M	L	M	L	L	L	M	M	OB/Gyn, Pediatrics
12	M	L	L	M	L	L	M	M	M	GP, FC, OB/Gyn

M = More; L=Less; NR = No Response; I= Improving

Issue 10 = Specialities in which females are preceived as naturally able.

mode and one of "do it for me, or to me". There is a great need for self-direction, self-effort and self-responsibility, particularly for young adults who have the attitude that "it won't happen to me". Therefore, a change in attitude may be a key to health care in the USA. Several respondents felt that this would involve early interventions such as establishing good health habits early on and helping keep them by being included in the elementary through high school curriculum. We in the AAO can influence change by beginning to talk about strategies that lead to self-direction, self-effort and self-responsibility.

Having been asked how we can be motivators of prevention, short of waiting for insurance companies to amass computed statistics to back claims (for example smoking) we can focus on control and keep "hammering away" at its importance and detrimental problems and further become regulators of our patients. We can aim at reimbursement of limited health screens; physicians can motivate patients toward prevention with subtle suggestions.

Regarding the delivery of good patient care, the time spent per patient office visit is important to the level of patient care — that is, taking appropriate history, physical diagnosis and appropriate treatment/counseling — and is described as the number of patients seen per day. Responses varied from 20 to 50 patients and in some cases 10 to 15 minutes per patient. It largely depends on the type of practice, such family practice or OMM, with or without cranial treatment, and the needs of the patients.

Societal Concerns

In exploring the issue of family care through education, respondents were asked if a required high school class in parenting skills including nutrition, discipline and responsibility should be required for all students. All responders agreed that such a course should be required. Their opinions as to when the course should be offered in general ranged from the ninth grade to throughout higher level education. Three leaders thought the earlier education in this area would begin, the better and encouraged starting during the preschool years. One believed that nutrition should be taught to young children through demonstration. Nutrition, discipline and responsibility are viewed as being absolutely essential.

In considering the effect of attorneys upon the physical and moral evils of society, respondents generally agreed about the need to cut the percentage of attorneys in government. This enables less complexity and opens a need for a broad spectrum of professions and others to be representatives of the populace. In addition, we need to decrease the numbers of financial managers in HMOs and "focus on being good doctors not providers. Give us back our identities so we can re-develop our respect." As for the attorneys, one such leader said, "They should be regulated by law, their fees, with caps, to be reported to the government for over-charging and excesses. Another stated, "Attorneys are a parasite on society. No group in the history of America has had so much control over others with no controls over themselves. In Germany, this allowed WWII to occur; in Russia, this allowed Stalin a reign of terror. This has allowed and insidious cancer to eat away at the American people. Accountability, culpability and sense of humanity are sorely needed."

Informants were asked if they felt a responsibility to society in the following areas. First, what responsibility do we have to point out the pitfalls of national health insurance and, if so, what type of alternate plan can we propose? Second can we, as leaders, help preserve the secret ballot? Third is the secret ballot important to an environment for osteopathy? Fourth, what factors have increased the cost of medical care or the cost of drugs? And fifth, how can we place importance on experience as a factor of status in medicine? The responses to these questions are summarized in Table 4.

Table 4 shows informants responses concerning several societal issues such as national health insurance, preventing the secret ballot, the cost of medical care and the importance of experience in medicine. In general, they favored pointing out a limitation of national health insurance, that of loss of freedom of choice of medical care-giver. They favored proposing an alternate plan for health care. They felt that the preservation of the secret ballot was important to the osteopathic profession. They thought that much of the increase in the cost of medicine was due to several factors, the first being the high cost of malpractice insurance, due to outrageous awards and a lack of tort reform. Second, two felt that high technology and heroic preservation of life have led to increased costs. Third, waste management of disposable and biohazardous materials, population longevity and the FDA were mentioned as leading to higher costs. Finally, responses concerning the importance of experience varied from those who questioned this factor to those who felt that it was most important.

Leadership Issues

In terms of the leadership of women through supervisory positions in osteopathic medical education and in health policy and finance, all agreed a need exists for increased female

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staffing in these positions. Key to this need, however, is they see women as having different ways of solving problems and listening. Thus, they base their views *least* on issues of equity with regard to disproportionate numbers of males and females in these positions and *more* on the need to bring in new perspectives. As one put it, "The position should be open to *the* most qualified DO regardless of sex." Likewise, they generally agreed that female DOs are under-represented on the AOA Board of Trustees, a seeming — in the words of one respondent — "good ole boys club". Another pointed out that currently only two females serve on the board, while another thought the addition of another female member may help the situation. However, a leader cautioned that few women would be willing to endure the rigors of getting there.

In comparing the remunerations given to males and females, all of the leaders agreed that women continue to be paid less than men doing the same work; some even indicated that studies pointed to this trend. Qualifying statements given by these leaders were as follows: a) the payments were often less, especially at hospitals and colleges, sometimes at female requests, b) "sometimes quotas are operative" and c) females who are willing to speak out are suppressed. These statements indicate that, as one put it, although the situation has improved in the last 40 years, much more needs to be done.

In order for females to assume leadership in our profession, the consensus was that women must become involved by actively participating in the state and national associations, as well as the specialty colleges. Perhaps the most forcefully stated of these statements was, "By standing up and voicing our opinions and not giving up at the first sign of resistance. I have seen many good women back off when confronted; this has got to be overcome. Unless we act on our convictions, we will never make a difference."

Of course, this entails doing good work, accepting positions, getting elected, being assertive, being competitive and contributing to meeting discussions.

Finally, when asked if we, as a group, possess sufficient skills in parliamentary procedure to achieve our goals, responses were split. Most believe that we do have sufficient skills in this area, but several thought that we do not. Of those that said we did not have sufficient skills, two thought that a simple solution could be found in educating ourselves better to use them — possibly this may involve joining a group devoted to improving public speaking skills — and another thought that parliamentary procedure is secondary to our goals, practice and professional groups.

Limitations of the Study

This study is limited by several factors, First, time did not allow the survey to be piloted. Hence, informants found several of the questions ambiguous. Second, the short turn-around time for the surveys made for a crowded schedule. Third, the written medium of the survey instrument precluded the possibility of asking follow-up questions that might have proved useful in clarifying the informants meaning. Thus, this survey instrument was limited by the lack of interactive communication. Finally, some of the survey questions were complex, having several parts and, understandably, the informants responses were complex and, therefore, more difficult to interpret.

Summary and Conclusion Communication

The findings about communication disclosed that factors of effective communication include a knowledgeable communicator who has a non-threatening speaking skill and depends upon the friendliness of the listener. Meaningful discussion further depends upon the knowledge on the part of the listener and his/her need to be in charge, as well as, the speaker knowing his topic.

Perception and Future of Women DOs

Those female osteopathic physicians who choose to assume leadership roles strike a balance between the demands of medical practice, quality family time and affordability of lower paying jobs. The income is expected to decline as the style of future medical practice with its intermediaries requires sharing the same health care dollar with financial managers and a host of others further splintering the time spent with the patient.

Health Care

It is equally apparent that rules and regulations of the health bureaucracy have gone overboard requiring increased paperwork and expense, and there is little interest in paying for prevention, least of all by insurance companies, since their business focuses on profitability, not reimbursement.

In order for female DOs to influence health issues, we need time and money for visibility.

Prevention involves knowledge, thoughtful planning and self-directed effort. The first two of these features may be influenced through education. Education, strangely enough, involves effective communication. The last

Table 4
Perceived Responsibilities to Society at Large

Inf.	Pop Contr	Alternate Plan	Secret Ballot	Env. for Osteopathy	Cost of Medical Care and Drugs	Experiences
1	+	+	+	+	Insurance health and malpractice	?
					lack of tort reform increase government redtape	
2	+	+ increase patient responsibility, patient makes informed decisions	+ +	+ +	cost of equipment cost of high technology equipment	one of the most important factors
3	+	+ all specialities give one free day a week to indigents need statute of limitations on mal-practice cases and cost of same	+	+	increase population longevity dishonesty	why should we have to prove anything
4	?	some sort of health care reform is necessary	?don't under-stand	?don't under-stand	malpractice defensive practice	don't know, the new E&M codes discount this
5	+	+ If we have an alternative plan	+	don't know what this means	greed, fraudulent billing, malpractice insurance premiums increasing due to lawsuits and outrageous awards	I don't know what you mean Experience important in medicine
6	+	NR	not sure	not sure	med. supply co. litigation waste management of	consistently excellent skills in history taking
7	+	NR	?	NR	yes, lawyers	NR
8	+	+ review plans of AOA AMA & AAFP, formulate a plan	+	+	Insurance, malpractice, technology, drugs, no good preventative plan	dismantle old boy's system of time put in to increase value of experience
9	+ resp. of all who hold this view	+ need a coalition of health care profes-sionals plan must include control of cost of prof. liability reason-able caps of awards, discontinue contingency fees for trial lawyers	NR	+ import. for any org.	greed, cost of practice including high professional liability premiums defensive medicine resulting in over-utilization, Medicaid reimbursement without a deductible paid by the patient	should contribute to one's expertise in medicine, this has to be accom-panied by contin-uous updated of ones self
10	NR	Basic care/Nat'l Health Ins. other dimensions for others	+	+	Heroic measures to preserve life instead of focus on optimal quality of life	by demonstration
11	+	+	+	+	Medicine is big business with big profits going to drug and technology development	NR
12	+	+	+	+	liability	?

feature is patient dependence on a friendly listener. Yet, it seems this requires incentives for motivation.

As we face national health insurance, we should take heed from the field of education that was historically provided without obligation of the student to actively seek to learn. A right to an education with obligation to perform has contributed to the deterioration of public education. When you get something seemingly for nothing, it is perceived as having no worth. Therefore, without responsibility in the form of patient effort and scaled co-payment, national health care is in jeopardy.

Historically, we have seen that health care benefits in the form of comprehensive insurance given to a select group such as auto workers has led to increased costs. When the coverage was extended to cover the cost of drugs, the auto worker's cost of insurance increased. Businesses are permitted to allot a certain amount of money for health care per worker. The unused portion of this allotment was included in totals of expenditures for health care which further confuses our understanding of the actual cost of health care.

Societal Issues

From the informants' responses and my own observations, I have the following thoughts and recommendations:

1) We need to strive for all-inclusive parenting skills and education at all levels covering the basics of nutrition, discipline and responsibility.

2) Reduce the large preponderance of attorneys representing us in government to 40 percent of current levels and regulate their fees and performance. Simplify the rules and regulations promulgated by having them written by non-attorneys and limiting the punitive damages to $100 or less.

3) Examine the large malpractice settlements in terms of their purpose and whose interests are served.

4) Request a copy of the spread of health care figures in dollars, no percent, identifying the high costs so that we know what we are talking about. Publicize the endless shifting of responsibility as a crisis.

5) Participate in the formulation of the national health care policy.

Leadership

From this attempt to describe the feelings and perceptions of these female leaders, I am left with several strong messages that seem to run through their responses. Their statements provide me with a glimpse of the disempowerment and marginalization that they have endured in the past, and in some ways continue to endure, despite their current positions within the profession and within the associations. Their replies conveyed to me something more precious than even this, however.

I found that beneath the, at times, angry rhetoric regarding what the "good ole boys clubs" have not done for women, the respondents have detected a definite change towards greater inclusion into leadership positions. This is based not simply on equitability but on the idea that females have unique perspectives and skills that will strengthen and improve the professions and the associations in which women leaders are involved.

It seems then, in closing, that much work remains to be done in facilitating women to assume positions of leadership. Certain barriers need to be removed; certain priorities need to be shifted. Although this study has attempted to reveal some perceived needs and future directions, an outline of the exact structure and nature of the reforms is beyond the scope of this work. One point, however, has been brought into sharper focus. These women leaders are speaking clearly and strongly for men and women to work together and, at times, to agree to disagree in the quest for change. These leaders are convinced that both men and women have unique leadership qualities to offer and that each can learn from the other if we — men and women alike — have the strength and the will to listen. It is my hope that their voices will be heard.

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How to Treat Your Employees

by Harlan O. L. Wright, DO

In a workshop I recently attended, Laurie Jones described several things that doctors could do to keep their employees happy and make them enthusiastic supporters. I have a few ideas that I use which might be of interest for future use.

Liz has worked for me for about 15 years and Janice for 8 or 9 years. In addition to paying them about 20 percent more than the going rate, I instituted several incentives when I left my former partnership to open up a new office 4 years ago. At that time we had a meeting and discussed what I expected of them and what they could expect of me. I set up an incentive plan for them which I have not ever seen extended to employees in a doctor's office. I told them that I appreciated their loyalty to me over the many years and for having opted to follow me to my new practice. I told them I did not want them to feel that they were only employees. I told them I wanted them to be part owners in the business. I felt this would give them adequate reason to "bend over backwards" to see that they did everything in their power to help the people who had entrusted their care to us.

I worked out an expense projection which would cover all office expenses and an adequate living expense base for me. I told them that if we collected more than that figure, one percent of the total gross income for the month would be theirs to be put in a profit sharing plan which would accumulate tax free. I also told them they would not be docked for any necessary time they had to take off for family matters or for illness (of which we have very little). Also, they would work only the time that I worked and that they would receive full pay for all off time.

Now this might be a rather dangerous plan for some offices to institute, but I thought if they had plenty of incentive to make the business work and prosper, they would not abuse it — and they have not.

Well, as a result, they each now have several thousand dollars in a profit sharing plan, and they have never missed getting their month-end bonus except for one month. Janice has become the best money collector that you could imagine and does so without making the patients mad. Both of the staff are on a first name basis with most of my patients, as am I, and touching and even hugging patients in our office is not an unusual sight to behold.

"My staff" is very loyal to me and my osteopathic practice and are tickled to death to work only four days a week and get a total of accumulated days off amounting to eight to ten weeks a year and still draw full pay and bonuses. They do not mind coming back at odd times or on days off to see patients or give shots or do a little work above and beyond the call of duty. As a result of all this, I probably do not make as much money as a lot of doctors, but I will bet I have the happiest and friendliest employees and the smoothest running practice in town. The atmosphere is a joy to work in and many of my patients tell me they just like to come into the office to see us and listen to the pretty music. How can you beat that? ❑

Classifieds

OMM/ Physical Medicine Physician

to join busy, well established practice in Colorado Springs, Colorado. Partnership or solo option available. Call Vincent Conner at (719) 260-8179.

New Orleans

Phyiatrist practicing orthopedic medicine (osteopathic techniques, prolotherapy) seeks DO to ultimately take over practice. Large physical therapy department; new medical office building 15 minutes from downtown New Orleans. Contact: Edna Doyle MD, 4224 Houma Boulevard, Suite 470, Metairie, Louisiana, 70006; (504) 456-5160.

OMM Externship Available

LCDR. James Lipton, DO, FAAO is soliciting applications from fourth year osteopathic medical school students for an OMM externship at Portsmouth Naval Hospital in Virginia Beach, Virginia. Interested parties should contact Dr. Lipton at (804) 398-7266.

Colorado

Opportunity immediately available for an OMT to join a private practice in Grand Junction, Colorado. Our medical practice is expanding and we are in the process of developing a health promotion center as well. Reply to: Catherine Princell, Health Partners, 1060 Orchard Avenue, Suite E, Grand Junction, Colorado, 81501.

Iowa

Major osteopathic college is seeking well credentialed, motivated and enthusiastic BC/BE osteopathic physicians to join an expanding department of osteopathic manipulative medicine. Position includes a good balance between patient care and didactic teaching. Excellent benefits with salary negotiable according to experience. Send letter of interest with CV and three professional references to David Boesler, DO, Chairman, Department of OMM, University of Osteopathic Medicine and Health Sciences, 3200 Grand Avenue, Des Moines, Iowa, 50312. The University is an equal opportunity employer.

Residency Plus-One

The University of North Texas Health Science Center at Fort Worth is currently accepting applications for positions in the Plus-One Residency in Osteopathic Manipulative Medicine. New this year, this one-year residency qualifies the physician to be eligible for certification in OMM. A completed residency in any other specialty is prerequisite for this program. Please address letter of application and curriculum vitae to David A. Vick, DO, Chairman, Department of OMM, UNTHSC-TCOM, 3500 Camp Bowie Boulevard, Fort Worth, Texas, 76107-2699; (817) 735-2461.

Associated Needed

Needed Associate; OMT practice with Cranial in Santa Cruz, California. Contact: Marcus Lay, DO, (408) 688-3112.

OMM Physician Needed

DO with manual medicine skills needed for progressive interdiscipline musculoskeletal clinic. Located on Maryland's eastern shore peninsula, close to ocean and Chesapeake Bay. Excellent benefits package, competitive salary depending on experience level. Call Dr. Sebastian (410) 742-3931 for details.

Jean-Pierre Barral, DO

Visceral Manipulation (Part 1) Videotapes

WVSOM, OMM Department
offers a complete set
of Dr. Barral
on Visceral Manipulation Part 1.
The only video cassettes
of his Part 1 course available.
Each set contains
(4) two-hour cassettes
(Edited from 21 hours of workshop)
Cost for complete set is ~~$320~~
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Contact:
WVSOM, OMT Dept.
400 N. Lee Street,
Lewisburg, WV 24901
(304) 645-6270

Classified Ad Deadline 10th of the month preceding publication.

Calendar of Events

SEPTEMBER

19-11
Midyear Seminar
Florida Osteopathic Medical Association
Hyatt Regency Westshore
Tampa, Florida
Contact: FOMA
(904) 878-7364

22-25
OMT Update plus
Preparation for OMM Boards
Walt Disney World Resorts
Orlando, Florida
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

22-25
23rd Annual Convention
New England Osteopathic Association
The Cliff House
Ogunquit, Maine
Contact: Nancy Dickey
Executive Secretary
New England Osteopathic Assn.
(207) 474-2357

OCTOBER

1-2
Fall CME
Rocky Mountain Academy of Osteopathic
Lion Square Lodge
Vail, Colorado
CME Hours: 7 Category 1-A
Contact: Charles B. Schaap, DO
Secretary-Treasurer
(303) 771-3102

7-9
SCTF Continuing Studies Course
Sutherland Cranial Teaching Foundation
UNECOM
Contact: Judy Staser
(817) 735-2498

9-15
National Osteopathic Medicine Week

22-23
Basic Percussion Vibrator Course
AAO Headquarters' Building
Indianapolis, Indiana
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

NOVEMBER

11-12
Osteopathic Manipulative Medicine's
(OMM) Boards
San Francisco, California
Contact: Susan Barnhart
AAO Administrative Assistnat
(317) 879-1881

13-17
AOA/AAO Convention
AAO Program: "The Objective Documentation of Somatic Dysfunction"
(BE SURE AND REGISTER AS AN ACADEMY MEMBER)
San Francisco, California
Contact: AAO
(317) 879-1881

JANUARY

14-21, 1995
AAO Western Caribbean Cruise
Program: "Joint Mobilization and Articulatory Technique"
CME Hours: 20 Category 1-A
Registration Deadline
NOVEMBER 1, 1994
Don't Miss Out on this Great Course plus a chance to visit Jamaica, Grand Cayman and Cozumel
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

FEBRUARY

11-12, 1995
Winter OMT Update
Adams Mark Hotel
Indianapolis, Indiana
CME: 18 Hours, Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

25-26, 1995
Ski & CME Midwinter Conference
Colorado Society of Osteopathic Medicine
Keystone Lodge & Resort
Keystone, Colorado
Contact: Patricia Ellis
(303) 322-1752

MARCH

22-25, 1995
AAO Annual Convocation
Program: New Horizons in Pain Management
Opryland Hotel
Nashville, Tennessee
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

APRIL

28-30, 1995
AAO Muscle Energy Course
Ramada Plaza Hotel
Indianapolis, Indiana
CME Hours: 20 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

The Academy Invites its Component Societies to send in their course schedules to be published in the AAO Journals and the AAO Newsletters.

THE OBJECTIVE DOCUMENTATION OF SOMATIC DYSFUNCTION

THEME FOR AAO PROGRAM IN SAN FRANCISCO, CALIFORNIA

IN CONJUNCTION WITH

AOA ANNUAL CONVENTION
NOVEMBER 13-17, 1994

BY NOW YOU SHOULD HAVE RECEIVE REGISTRATION INFORMATION.

WE INVITE YOU TO

SUPPORT THE ACADEMY BY REGISTERING AS AN ACADEMY MEMBER!

MARK CANTIERI, DO, PROGRAM CHAIRPERSON

American Academy of Osteopathy

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