THE AAO
JOURNAL
A Publication of the American Academy of Osteopathy

VOLUME 4 NUMBER 1 SPRING 1994

Scott Memorial Lecturer Speaks to Founder of Osteopathy

...see page 9

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

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From the Editor

Lessons From Geese

I recently read something very interesting about geese. Now, I usually don't spend much time pursuing facts about geese, but this information crossed my path and I was impressed by it. In fact, it got me thinking again about osteopathic unity. We have heard a lot in recent years about the need for unity in the osteopathic profession. It has been a major theme of the AOA over the last few years, and I have written about the topic in this column as well. With all the concern with what may be happening with health care reform, I think establishing more unity within our profession is more critical than ever, and the subject bears revisiting. Perhaps, then, you can bear one more dissertation about osteopathic unity.

So what do geese have to do with osteopathic unity? Well, let me preface this with the confession that I believe we can learn valuable lessons from birds and animals. Often it seems to me that these creatures seem to know just the right way to approach life. They don't ask for much from the world, or from us as humans, and yet they always seem to have just what they need. No wasted energy, just practical living. We can learn a lot by observing birds, animals and nature in general.

What I learned about geese (and how it relates to osteopathic unity) comes from an excerpt from a talk given by anthropologist Angeles Arrien. This talk was originally published in the newsletter of the Maryland Association of Extension Home Economists and reprinted in the October 1993 issue of *Evaluation Practice*, the journal of the American Evaluation Association. The excerpt is as follows:

Fact 1. As each bird flaps its wings, it creates an uplift for the bird following. By flying in a V formation, the whole flock adds 71 percent greater flying range than if one bird flew alone.

Lesson 1. People who share a common direction and sense of community can get where they're going quicker and easier because they're traveling on the strength of one another.

Fact 2. Whenever a goose falls out of formation, it suddenly feels the drag and resistance of trying to fly alone and quickly gets back into formation to take advantage of the lifting power of the bird immediately in front.

Lesson 2. If we have as much sense as geese, we will stay in formation with those who are ahead of where we want to go and be willing to accept their help as well as give ours to others.

Fact 3. When the lead goose gets tired, it rotates back into formation and another goose flies the point position.

Lesson 3. It pays to take turns doing the hard tasks and sharing leadership.

Fact 4. The geese in formation honked from behind to encourage those up front to keep up their speed.

Lesson 4. We need to make sure our honking from behind is encouraging and not something else.

Fact 5. When a goose gets sick or wounded or shot down, two geese drop out of formation and follow it down to help and protect it. They stay with it until it is able to fly again or dies. Then they launch on their own, with another formation, or catch up with their flock.

Lesson 5. If we have as much sense as geese, we, too, will stand by each other in difficult times as well as when we are strong.

Osteopathic unity. We could learn a lot from geese. ❑

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:

Manuscript

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.

Illustrations

1. Be sure that illustrations submitted are clearly labeled.

2. Photos should be submitted as 5" x 7" glossy black and white prints with high contrast. On the back of each, clearly indicate the top of the photo. Use a photocopy to indicate the placement of arrows and other markers on the photos. If color is necessary, submit clearly labeled 35 mm slides with the tops marked on the frames. All illustrations will be returned to the authors of published manuscripts.

3. Include a caption for each figure.

Permissions

Obtain written permission from the publisher and author to use previously published illustrations and submit these letters with the manuscript. You also must obtain written permission from patients to use their photos if there is a possibility that they might be identified. In the case of children, permission must be obtained from a parent or guardian.

References

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:

I came into possession of Volume 3, Number 3, Fall, 1993 issue of *The AAO Journal* to read my dad's article, "Osteopathic Medicine," by James A. Keller, DO. I subsequently read the entire issue cover to cover.

My compliments to you and the AAO for making such a good case for the appropriate and frequent application of OMT to a wide variety of conditions. While these compliments are well deserved and are hereby conveyed, I thought it might be beneficial for your readership to consider this letter, which I might entitle, "Osteopathy as Viewed From the Other Side of the Desk."

From the first sentence, the casual observer can tell that I am not without bias with regard to the place of manipulative diagnosis and therapy in the practice of Osteopathy. I am, however, a uniquely qualified observer for such a task, knowing some of the potential of OMT to promote healing and health, as well as knowing the public or patient side of the desk for some 35 or so years, in which OMT was either not available to me and my family at all, or available at great expense of time, travel and money (160 miles one way).

My mother was a registered nurse, and I was carefully trained not to tell everything I knew, so I spent the first 21 years of my life hearing the effects of OMT detailed at breakfast, lunch and dinner, and being the guinea pig while Dad discussed and demonstrated techniques with colleagues or with one of his two brothers. I know first hand what Robert C. Clark, DO is talking about in his article "We Need National Health — Not National Health Insurance," when he says that some consider him a miracle worker. I observed a man for several minutes as he approached my dad's office which occupied the front part of our house. He was fighting with a pair of crutches to navigate the sidewalk and steps to the porch. I saw him again a few minutes later, as he came out at a brisk, confident walk, with the crutches under his arm. That was in Louisiana where the practice of Osteopathy was limited at that time to manipulation only, so there was no miracle drug involved. I attended one year at KCOM, during which time I learned more about the heritage left by the Father of Osteopathy, Dr. Andrew Taylor Still.

I need not go over any more successes of OMT to convince the readers of *AAO Journal* — just the issue I read is plenteously supplied with testimonials of the efficacy of OMT to help maintain and/or regain health. Let me tell you now of the dilemma that knowledge puts me in "out in the public."

The last 35 years or so of my life have been invested primarily in work around men and women with the full gamut of conditions. Let me list a few of the more common complaints I have either heard from others or experienced. Sleepless nights because of hands and arms "going to sleep", sore neck, sore back, can't walk straight after lifting crooked, had appendix out, but it still hurts, wives during gestation experiencing severe edema and/or suffering low back pain from displaced center of gravity and on and on. You get the picture. Then there are the numerous cases I hear about and see the effects of — a person lifts crooked and their back "catches", a fellow chops wood all day (an unusual task for him) and in the morning he has a "cramp" in his back. The pain persists since no one can be found who can put a stop to it. The doctor just dulls it with drugs. The pain persists. He is sent to a specialist, a surgeon, who obligingly "helps" the "slipped disc" by fusing the spine. (I have dissected one of those things and how a person could speak of a disc "slipping" with a straight face is beyond me — herniating maybe, with enough impact. I am certain that discs bulge enough to be seen on x-rays when the surrounding muscles are tense enough for long enough, but slip? Come on!!)

What do I tell my friends and coworkers when I can't find a good OMT myself? I used to be able to drive 160 miles for an OMT. I can't do that now, so what do I tell them? I called one so-called DO's office and was informed "he doesn't give that kind of treatment." That was after I had gone in to another DO's office, got through the history taking, blood pressure, and temperature that goes with what in my locality brings a very expensive "first visit charge" to be told, "Take a couple of these every so often, and if you don't feel better in a couple of days come back." The unspoken part was obvious, ". . . and I'll get you for another 40 bucks!" Other than to take my blood pressure, not a hand was laid on my body for either diagnosis or treatment. I called another office of a DO who was reputed to give OMT. The receptionist's response was, "Yes, he gives manipulative treatments, but he is booked up and does not accept new patients." I wonder why! The best I have been able to do for several years was with a chiropractor who had somehow apprenticed himself to a good DO long enough to get a full arsenal of techniques with which to help his patients. When I moved to another town a number of miles away, I tried a few other chiropractors only to find trendy little tricks, fancy tables

Continued on page 31

Message from the President

I'm flying home from a meeting of the AOA Council on Federal Health Programs. Steve Noone. John Cifala, DO and I met with other leaders in the osteopathic community to aid the AOA in planning and establishing input into the governmental health reform plans. The AOA and its affiliates want to make sure that any changes will be as positive as possible for osteopathic physicians and our practices.

Last week about 70 people returned from a 7-day CME Caribbean cruise. Thirty-seven participating doctors and five faculty enjoyed a course in basic thrust techniques. This course/cruise was a step in the continued expansion of the AAO's CME offerings. Next year we intend to plan more and varied CME. Contact Boyd Buser, DO, the Chair of the Education Committee, if you have any bright ideas regarding future CME.

This January CPT added osteopathic manipulative treatment codes 98925-98929 to replace the HCFA's procedural codes M0702-M0730. These CPT codes are category (1) codes and should be accepted by third party payers and thus reimbursement should be better with less hassle. By the time this is printed, each member should have received from the AOA a packet of information explaining the new codes and how to use them. Judith O'Connell, DO co-chaired the AOA committee that produced the information packet. Judith Lewis, DO and I served on this committee. Dr. Lewis and the AAO Medical Economics Committee have been busy in many areas, including producing a brief video tape presentation introducing osteopathic practices and how these relate to the new CPT codes.

My term as AAO President is rapidly drawing to an end. It has been a busy time with many demands and opportunities. This year we have been involved in the new CPT codes, new CME, increasing activity, cooperation and potential influence with AOA, HCFA, RUC and other legislative bodies and policy makers. With these and many other efforts, we are striving to serve you better and lead the osteopathic profession into its proper place in the health care community — at the apex.

Throughout my tenure, I have encouraged involvement. Now is an opportunity for each of us to become involved. Congress is considering House Concurrent Resolution 173 — "The Osteopathic Awareness and Appreciation Act." This act recognizes the contributions of the osteopathic profession and requires our inclusion in any health reform. This bill was introduced by Rep. Barcia (D-MI). It is officially cosponsored by: Bilirakis (R-FL), Brown (D-OH), Kildee (D-MI), Skelton (D-MO), Strickland (D-OH), Towns (D-NY), Wyden (D-OR), Andrews (D-NJ), Kreidler (D-WA), Geren (D-TX), Slattery (D-KS), Dellums (D-CA), Manton (D-KY), Brewster (D-OK), Jacobs (D-IN), Greenwood (R-PA), Emerson (R-MO), Hoekstra (R-MI), Upton (R-MI), Traficant (D-OH), Hall (D-OH) and, hopefully, many others by the time of this publication. We need to send a letter of thanks to our representatives who support us. We need to request support from those who have not already cosponsored. We need as many congressional supporters as possible to insure passage of this historic legislation. Stacy Bohlen of the AOA Washington office is coordinating this effort. She can be reached at 300 Fifth Street NorthEast, Washington, DC 20002, phone (800) 962-9008, fax (202) 544-3525.

I have been told that legislators are swayed by the quantity of correspondence received on an issue. If your representative is unsure whether to support or cosponsor a bill, if letters from you, your family, friends and patients are received strongly supportive of that bill, then your legislator is far more likely to support or cosponsor that bill.

Get involved or
don't complain
about the outcome!

I am looking forward to seeing you at convocation, March 23-26 at The Broadmoor Hotel in Colorado Springs where we will look at osteopathy from the "inside out".

May God's richest blessings be yours always.

Herbert A. Yates, DO, FAAO

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The Honorable _____
US House of Representatives
Washington, DC 20515

The Honorable _____
US Senate
Washington, DC 20510

Message from the Executive Director

Stephen J. Noone, CAE

Education Committee Expands CME Offerings

Chairman **Boyd Buser** and the Education Committee met at the AAO headquarters February 4-6 and reviewed the performance of the Academy's educational programs from the past year as well as planned for the future. Based on the success of previous programs, the Committee will explore the feasibility of adding two additional programs for 1995. The *tentative schedule* through 1995 is the following:

1994

May 21-22	Advanced Percussion Vibrator in Indy
Sep 22-25	OMT Update/Board Prep Course in Orlando
Oct (TBA)	Basic Percussion Vibrator Course in Indy
Nov 13-17	AOA Convention in San Francisco

1995

Jan 14-21	Cruise/CME in Caribbean
Feb (TBA)	OMT Update in Indy
Mar 22-25	Convocation at Opryland
Apr (TBA)	Basic Muscle Energy
May (TBA)	Advanced Percussion Vibrator
Aug (TBA)	Visceral Manipulation
Sep (TBA)	OMT Update, West Coast
Oct 15-19	AOA Convention in Orlando
Nov (TBA)	Basic Percussion Vibrator

AAO Membership Continues to Grow

On January 31, there were 79 AAO members (43 Active, 13 Second Year, one Associate and 22 Residents) who were dropped from the current roster since they had not paid their 1993-1994 membership dues. Nevertheless, Membership Chairman **John Glover** reports that the numbers continue to rise, with this chart comparing year-to-date data with the numbers from March 12, 1993:

Category	'93-'94	'92-'93
Active	722	684
2nd Year	60	57
1st Year	48	61
Joint Active	20	12
Supporter	4	2
Associate	19	2
Res/Intern	267	162
Retired	47	47
Life Mbr.	66	66
Honorary	8	7
Waived	5	2
Total	1,265	1,102

Cranial Academy Meets in Indianapolis

President **Michael Lockwood** convened the Cranial Academy's Long Range Planning Committee in Indianapolis last weekend to review the progress of the CA in recent months, to discuss the findings of the recent survey of a cross-section of members and to implement the five-year stragegic plan for the organization. Other CA leaders present included **Eric Dolgin, David Coffey, Richard Feely, Dallas Hessler, Karen Sept, Denise Speed, Scott Sutherland** and Executive Director **Pat Crampton**. The group took some time out of their weekend to tour the CA and Academy headquarters and visit informally with the AAO's Education Committee.

Planning facilitator, **Wilford Butler** pointed to the real and sustained progress and improvement made in the work of The Cranial Academy and commended its leadership. He pointed out that the responses from members to the survey were overwhelmingly positive and that members could identify the important changes taking place.

The group focused on strengths, weaknesses, opportunities and threats. The mission statement was reaffirmed as the Committee began the visioning process. Strategic initiatives were identified and an implementation schedule was developed.

AAO Publishes New Brochure

The Academy has a new brochure entitled "*Osteopathic Medicine: A Distinctive Branch of Mainstream Medical Care.*" Members may purchase copies in quantities of 25. Call the AAO office today for a sample and order form! ❑

ENCOURAGE YOUR COLLEAGUES TO BECOME BOARD CERTIFIED IN OMM

An Imaginary Talk with Dr. Still - 1993

by Martyn E. Richardson, DO, FACOP

It is both an honor and a challenge to be asked to deliver the Scott Memorial Lecture. I read Research and Practice, *scanned by father's writings, reviewed by clippings from 1940 to date, and thought about the differences in practice from 1900 until today.*

It was while I was sitting on a rocky ledge, looking at the ocean surf pounding below me, the seals playing in the water and in the distance, a lobsterman pulling my favorite protein food onto his board, that I imagined I was talking with Dr. Still to see how he would respond to all of these changes based on his "Platform", page 11, Research and Practice.

Please understand that my research, observations and anecdotes are general and that reference to "regular" medicine refers to organized and political medicine and does not refer to those individual MDs, clinics and hospitals which understood and were sympathetic to the osteopathic profession.

Dr. Still: Tell me how our profession is faring. I know your father was an early graduate of Philadelphia and wrote a lot. So what's going on?

Martyn: What do you know?

Dr. Still: I know things are a lot different, but I don't know much about our profession. Has it grown?

Martyn: Yes! There are about 35,000 graduates of osteopathic colleges, but I don't know how many DOs.

Dr. Still: That must mean a lot of colleges. I hope they are good. I wanted the curriculum to be almost exclusively anatomy and physiology and osteopathic manipulation. I recall that there was much discussion in the 1890's before Materiae Media was introduced into the curriculum, and the curriculum was expanded with the building of the infirmary and the hospital in the late 90's. What has happened since?

Martyn: As the graduates from Kirksville and the other young colleges spread across the country - many began new osteopathic schools. This trend was common in professional colleges. (It was reported that in 1900 there were more medical schools in the U.S. than in the rest of the world.) There were an estimated 38 osteopathic colleges, 22 registered by the AOA, between 1900 and 1943.

These colleges taught osteopathic medicine with varying abilities but adjacent colleges competed vigorously. Mary Jane Denslow described the fights between the students of the two colleges in Kirksville.

The Flexner report of 1910 condemning medical education of the era led to "improvements" in medical education and a decrease in the number of medical schools. By 1943 there were only six osteopathic colleges. The faculty consisted of DOs and some PhDs who were courageous and individualistic and believed in the philosophy of osteopathy.

As I recall, in those days we had two years of anatomy (memorizing Cunningham's dissectors!), a stimulating physiologist, an alternative type biochemist and GP physicians teaching in "specialties." Class sizes were small enough so that you knew your professors.

My notes for the clinical lectures all ended with the initials SOS, - "same old stuff" which included dietary adjustment, non-drug temperature control and osteopathic manipulative therapy (roll the bones they will come home) along with "specifics". OMT was taught by all the clinicians, but we spent time enthusiastically practicing required to give "treatment" to every patient daily.

But what was happening? The osteopathic profession was attempting to "improve" its educational curriculum to obtain legal recognition in states and national health care agencies, particularly difficult with the increasingly aggressive stance of political medicine to eliminate the osteopathic profession peaking in the California episode in the early 60s. This led to more basic scientists on faculty, many with their primary research interests in other than osteopathy and many of whose

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teaching demanded more hours to teach basic science (as if the student were a PhD candidate). Anatomy time was decreased, and clinical subjects were increasingly taught by more and more specialistic oriented DOs.

There was no "SOS" in the teaching. Government funding for increased enrollment eliminated the personal attention of earlier days. But the profession continued with its goal of developing GPs in rotations, internships and osteopathic-oriented residencies until recently when - one by one - the requirements are being modified to allow for more specialistic and non-osteopathic programs.

Today in evaluating patient records during hospital surveys, we can tell at a glance who did the history and physical. The student is very complete with osteopathic findings, the intern perhaps a little less complete, the resident makes a progress note focused on the specialty, and with a few notable exceptions, the attending physician scribbles a short note. This appears to be the process of unlearning good physical diagnosis and M/S evaluations.

During the same period, the medical profession, responding to Flexner's report and increased scientific information (not necessarily knowledge, and much changing from year to year) was focusing entrance requirements on academics, eliminating early patient contact, allowing or encouraging early choice in specialization. The loss of FMGs and retirement of the older family practitioners and the changes in medical economics have caused the medical profession to suddenly decide that they are going to change their curriculum in an innovative way emphasizing the teaching of primary care. I have 40 articles from 1960 to 1993 by MDs who were critical of medical education. These articles indicated: "fragmented medical education, we must reduce memorization of factual information, need to integrate teaching - to teach cooperation between specialists, restore individualism, too much lab, no physical diagnosis, no time to mix with experienced physicians, we should require only two years of premed, pay more attention to humanities in admission, return to rotating internship.'93 John Hopkins - immediate contact with hospital patients, fewer lectures, office practice, ethical (and financial) issues."

So as the osteopathic profession has made motions toward more specialization and less osteopathy (with all that means), the medical profession is trying to return to more patient-oriented family practice focus, and more and more MDs are studying manipulation.

But, so much of this manipulation is directed toward back pain, ignoring the effects of structural stress in causing or aggravating discomfort and/or dysfunction in organs or systems in other parts of the body, the philosophy which you, Dr. Still, emphasized and which has been clearly elucidated by Korr and others, including the '43 classmate, Wilbur Cole, who received worldwide recognition for his identification of the motor end plate and served many years as the Dean of Kansas City.

The osteopathic profession is in a unique position of continuing to do what the medical schools (and hospitals) claim they want to do and the government and people say must be done.

Dr. Still: "I told you so, now let's get back to basics. We believe in sanitation and hygiene. Are they teaching it?"

Martyn: 1925 - quoted in Right Living by M.L. Richardson: "Modern medicine has all but driven from the face of the earth plagues that at one time decimated continents - true, the credit cannot rightfully go to drugs and medicines ... but to those great by-products of medical research: prevention, isolation, quarantine, sanitation, hygiene, dietetics and asepsis." The increase in life expectancy may be more the result of public health activity than medical "progress".

Today, the attention to "sanitation and hygiene" continues and is essential to the health of a community. Whenever this breaks down - in war, poverty, hurricanes, floods, air conditioning (Legionnaires' Disease), food preparation (E. coli in hamburgers) some or many people are adversely affected.

Dr. Still: I see. I notice that you mentioned dietetics. You know what I felt about that!

Martyn: Yes, I have some quotes of yours.

"What will you feed it?"

"Fried breakfast bacon - oils the intestine. Diet cuts but little figure with me - usual diet of the home habit is best - use good common sense."

For diarrhea: "Diet as is easily digested keeping nuts and fresh fruits out of the way. Fresh buttermilk is good, ordinary bread always acceptable, but any mother should know enough to keep trash away from her child at such times."

"As to nourishment, I think the adult patient knows what and how

much to eat and when to quit."

"I think my advice is more needed on his back more than at the table. I cannot afford to waste much time on dietetics." Then you mention honey "had a popular place with the pioneers in kidney disease" and "the more honey one eats the sooner the spine and kidneys get better."

One's first impression might be that you, Dr. Still, missed an important subject for proper growth and development and maintenance of good health. However, you were writing at a time when people did know what to eat, from primitive tribes to Europe to the native Americans and the pioneers, much through trial and error and experience. Much food was home grown or wild.

The DOs in the 20s expressed continuing concern about diet. The DOs I knew did not use salt, had "sweet" (unsalted) butter, used no frying (in lard) of goods, allowed no white sugar, no white flour, no fat gravy, no fried potatoes. They did not use aluminum cooking utensils, believing that **aluminum was toxic.**

Foods were baked or boiled in small quantities of water, whole wheat breads, bran and whole grain cereals, with nuts, raisins, dates, banana or other fruits, baked potatoes, lots of fresh salads, olive oil, honey (and cod liver oil and brewers yeast for vitamins).

My father traced the decline of the American diet to World War I, when salts and other preserving processes were required to send food by ships to the troops in Europe. Many rural individuals were first introduced to the goodies, candy, preserved foods, salt-white bread, white sugar, etc., in the service.

However, as work changed from calorie consuming manual labor to more machines and sedentary labor, people tended to continue their old dietary habits, but the increasing supply was more commercial - foods developed for their appearance or ease of mechanical harvesting, rather than nutritional value - grown on exhausted land with chemical fertilizers, not to mention weed killers and pesticides, and shipped long distances. Further, eating habits were influenced by advertisements and supermarket displays of junk foods.

The scientists, physicians, and FDA all neglected, ignored or scorned the importance of diet and vitamins and minerals for humans. The book, *Vitamin E for the sick and Ailing Heart* and Paulings' work possibly opened this field to public discussion.

Today the trend is back to more natural foods - less fat, less salt, whole grains, bran, fish, reasonable vitamin mineral supplements, etc. You all know this, but do you advise your patients? Most physicians do not spend time on instructing about diets and nutritionists did not score too well on tests about nutritional requirements, leaving the individual to attempt to evaluate confusing media reports. And medical schools are not teaching much about the subject.

Dr. Still: Things have changed, but it is important to put the proper fuel in the human machine!

"We are opposed to vaccination."

"We are opposed to the use of serums in the treatment of disease."

Is this being taught?

Martyn: For the era, I feel that you, Dr. Still, were justified in this opposition. Vaccines were crude and various sera were touted to cure all types of conditions.

In the last 100 years, improved vaccines have resulted in the elimination of smallpox from the world, the reduction of polio, diphtheria, certain pneumonias, pertussis, and rabies and tetanus in humans. Endemic measles would have been eliminated by 1985 if federal funding had not been cut in 1980. True, there have been problems, some reactions to pertussis, a polio vaccine which caused polio, the swine flu vaccine fiasco, failure of hepatitis B vaccine and other problems. Immune serum globulin, blood factors for hemophiliacs, blood transfusions (although overused) have been of help.

Dr. Still: I guess that this is okay since it depends on or stimulates the body's own immune system, but osteopathic manipulation stimulates immune response plus provides drainage of toxins from the body and enables a fresh supply of healing blood to get to the area, aiding in recovery. What about the common cold, bronchitis and pneumonia? There is no vaccine for those. Now, to the next principle.

"We realize that many cases require surgical treatment... as a last resort."

Martyn: Surgery in that era of early antisepsis, asepsis and anesthesia required a hospital and the first was constructed as an addition to the infirmary in 1899 although there had been a maternity unit since 1895.

About maternity cases - you did not mention much about manipulation during pregnancy, but many DOs feel it is of value. A unique program at WVSOM under the direction of Paul Kleeman in the early 80s had second-year students care for OB cases for nine months, administering regular manipulation as the contours of the

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spine changed, with delivery at the birthing center and less than one percent complications. The DO has long used manipulation in OB cases and it is too bad that "scientific" studies have not been published.

In the early days, osteopathic physicians went into general office practice, but DOs and MDs worked together effectively on the staffs of many hospitals until 1918 when political medicine shifted from ignoring osteopathy to a more active policy of opposition, including prohibition against MDs consulting with DOs or DOs being on hospital staffs, continuing until after the Kline report years later. I have the letter sent to my father in 1920 informing him that MDs would no longer be permitted to consult with him.

But after the 1918 policy, the physicians who had been assisting in surgery or had "enjoyed" the pleasure of hospital membership began to develop their own hospitals. These hospitals were often in apartments or large homes where the DOs had a place to deliver babies, care for pneumonia and do surgery. Some were owned by an individual, others by groups of DOs who pledged money for renovation and painted walls, swept the floors, bought the groceries, and paid a "bed tax" of $1.00 per day for each patient. The DOs and hospitals identified themselves as osteopathic.

Hospital stays were seven to ten days, giving patients, nurses, staff and the DOs (administering daily OMT) opportunity to become friends, and to become a force in obtaining recognition. DOs received some training in surgery or learned by reading. Hospitals with no surgeon arranged for an itinerant surgeon to travel to hospitals on a regular schedule.

The important thing was that these were GPs - family physicians, who provided a continuum of care to the patient and presumably good osteopathic manipulation before surgery, and we know that every patient received general and specific osteopathic manipulation after surgery, since proven to be of value in Dr. Stile's study in Waterville, Maine.

The ACOS began accrediting hospitals in the 30s; later this was assumed by the AOA. In 1953 almost 400 hospitals were listed. By 1963 there were 186 listed, about 35 (including one of the largest and best osteopathic hospitals - L.A. County) having been lost in the California episode.

The remaining hospitals expanded and prospered, as federal funding became available. Many graduates took residencies in osteopathic programs but others (about the time they stopped wearing ties and white coats and showed up in jeans and flowered shirts) went into allopathic programs either denying osteopathic principles or rapidly losing their basic skills in palpatory diagnosis and manipulation. They became specialists, like the young MDs.

The previously "routine osteopathic manipulative therapy" was no longer accepted but must be ordered for each patient. So the DOs had given manipulation in the past but had not documented it; now the new DOs did not do manipulation and documented why not.

After the Kline report decided that DOs were not cultists, and there were fewer general practice MDs and the supply of foreign medical graduates declined, MD hospitals began to recruit general practice DOs, many of whom deserted the osteopathic hospitals which had nurtured them or even set them up in practice to become supporters of an organization which had exerted all its efforts to eliminate the college and profession which had given these individuals the opportunity to become doctors.

With the change in practices many DO hospitals closed - some due to stubbornness of DO owners, self-serving Board members, or bitter medical rivalries - others consolidated or were sold to profit-making health care organizations. Many changed their name from "Podunk Osteopathic Hospital" to "Greater Podunk Complete Surgical, Psychiatric, Rehabilitation, Substance Abuse and Everlasting Health Center." There are only about 70 DO hospitals left today.

At the same time, MD hospitals (about 60 at this time) applied for accreditation from the AOA to establish internships and GP/FP residencies further depleting house staff in DO hospitals and in all hospitals there is pressure to reduce hospital stays and do "procedures" as outpatients, there is less time to study the patient, less thorough histories and physical examinations, more dependence on expensive high-tech testing to focus on one organ or system rather than the entire person and failure to consider the osteopathic musculoskeletal changes as causing, contributing to or complicating the patients' problems and recovery.

Dr. Still: I am so sorry to hear about all this but I hope surgery is done as a last resort and for proper reasons. Many surgeries are unnecessary.

Martyn: As surveyors for the AOA we have seen patients with removal of normal organs, hysterectomies in 20-year-olds without documented justification, repeated surgeries for the same symptoms in the patient (Munchausen's syndrome) and other cases in which prior conservative efforts including osteopathic manipulation are not documented.

There is adequate evidence of unnecessary surgeries in the USA today in the literature, and we frequently find no chart evidence that surgery is being done according to your dictate, "as a last resort," and no consideration of osteopathic lesion as a cause of gastric distress, headaches and multiple other problems not identified by CAT, MRI, etc.

Dr. Still, there is one unique approach of the early DOs that seems to have been lost. Using the work of the 16th century Bartolommeo Eustachio and the experiments of Guyort who in 1724 treated his own deafness by inserting a tube into his Eustachian tube, ear specialists were using insufflation to overcome hearing loss. A small group of DOs followed the lead of Curtis Muncie, DO, in utilizing early cranial osteopathic manipulation with finger dilitation and manual "reconstruction" of the Eustachian fossa, posterior nasal pharynx and Eustachian tube area, apparently obtaining significant improvement in head noises and hearing loss. (My father had many patients who came from hundreds of miles away.) These DOs manually drained tonsils as you had mentioned and preserved them as essential to health.

Paul Williamson, MD, in the 50s recommended finger crushing of adenoids rather than amputating with the sluder, which avoided the surgical scar, and stimulated the immune system to overcome the infection.

Dr. Still: I always had a friendly feeling for other non-drug, natural methods of healing, but we do not incorporate any other methods into our system. What has happened to those methods?

Martyn: The incubator of medicine, as you described, has many eggs - some centuries old, and many "ologies" - some with hands-on types of care - none ever evaluated by the medical profession until under pressure from the public to do so. Dr. Oliver Wendell Holmes spoke in the highest terms of the patience and devotion of physicians but could never condone the obliquities of character which, as a profession, they arrogantly displayed against anything out of regular medicine. In the late 1800s he wrote, "The regulars may smile or groan at the presumption of an irregular restoring health to the sick. Satiated by the useless practice of ages, infected by a bilious temperament antagonistic to any unorthodox truth, he peers out through his jaundiced eyes and sees everything yellow."

Dr. Still: I have always opposed drugs as remedial agents.

Martyn: I do not know what you classify as "drugs", but there are many natural substances and inexpensive preparations which are of value, and your idea that the brain makes its medicines has been proven. Unfortunately, the drug companies are a major industry and political force in the country. They tend to concentrate on new and increasingly expensive drugs and using marketing to encourage doctors to use the newest. Many patients take 8-10-12 kinds of medicine at a time -- not good practice for any physician.

Dr. Still: The fundamental principles of osteopathy are different ... disease is the result of anatomical abnormalities followed by physiological discord. To cure disease, the abnormal parts must be adjusted to the normal..." How is that being adhered to?

Martyn: Sorrowfully, I must admit, not too well. Some students have the impression they are learning medicine plus a course in manipulation. Interns and residents are not required to perform a meaningful osteopathic M/S evaluation or to administer manipulative therapy (with a few exceptions). Those interested in manipulation take a residency. Those who limit their practice to manipulation may have referrals of patients with backaches, but their patients are often the ones who understand and appreciate the value of regular manipulative therapy. In many areas, patients who believe in osteopathic manipulation cannot find a DO who is good at and will provide manipulative care. Many DOs refer patients to physical therapists or respiratory therapists for these problems. At the same time that DOs tend to forget manipulation, more and more MDs are interested in and learning manipulation.

Earlier, I said there were 35,000 graduates of osteopathic schools but, I'm not certain how many consider the osteopathic philosophy or do any manipulation.

Fortunately, there are still old

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times and many newer graduates who, in their family and special practices, do use manipulation both for backache, acute illnesses and chronic conditions.

Dr. Still: You keep mentioning government and insurance companies. What is that all about?

Martyn: After the development of antibiotics and cortisone (both naturally occurring) and surgery become more complex, companies eliminated their company doctors and provided health insurance to their workers. Later, the government provided Medicare and Medicaid; these plans did not pay for office visits or maintenance of health. So everyone went to the best hospitals, causing the closing of many good county hospitals and the surge of profit-making health companies. The government gave money to build more hospital beds and to train more doctors. Doctors developed more extensive and expensive testing equipment and procedures, and many seemed to want to get rich quick. So the government tried to control this with Certificate of Need, by limiting prices and stays in hospitals and creating reams of paper work.

In the '60s there were articles about the crisis in health care and 30 years later there are efforts to do something. But so far, every government action has accelerated the increase in cost.

Dr. Still: So where is the profession today?

Martyn: I don't know. Should I answer that the profession peaked in the 70s and 80s, with new colleges, gaining wide acceptance in public institutions, military and government? It has become firmly established with hospitals expanding in size and scope of services and every one is successful.

Or, should I say success went to our heads? When we could stop fighting for our existence as a group, our interest turned to our own individual welfare and profits. Did we choose students who were not motivated? Did we fry their brains with so much science that they never absorbed the philosophy or understood manipulation? Are we a duplex profession of either physicians or manipulators?

Or, can I say after a period of consolidation of our legal and economic gains we are now in position to develop the best physicians, to apply the philosophies, to broaden manipulative therapy to where it is once again a part of therapy for maintaining health and treating dysfunction and disease - as you preached?

What do you think, Dr. Still?

Dr. Still: I started this profession because of the failures of organized medicine. Others were also questioning the medical practices of the time. But I think my theories were and are the most complete.

The students had to be those who were of a different cloth - willing to travel new paths, willing to suffer the antagonism of organized medicine, willing to be different. Some of these traits led students to try unacceptable methods, or to out perform the experts in the field of medicine or surgery. But I hope they will retain and utilize the ideas that the human body will heal itself if the obstructions are removed.

The profession has been doing things properly for 100 years. It has gone from a defensive attitude to proving it is as good as the regulars and now is in the position of being at the forefront of the education of doctors and delivery of care for the next century.

The osteopathic colleges should continue to do what they do best and resist the pressures to become more like allopathic colleges. Let us reduce memorization of facts and teach principles in basic science. Let us emphasize anatomy, physiology, neurology and relate it to the human body and its dysfunctions. Let the clinicians include the manipulative osteopathic findings and manipulative management in all of their presentations and those who are osteopathic manipulative specialists integrate the best of all of health measures including "alternative medicine" into their teaching. Let us introduce students early and continuously to people who seek care in doctors' offices - the 98 percent of problems which do not need hospital care - and emphasize prevention by good life-style and body mechanics. In post doctoral training programs let us demand a proper osteopathic evaluation and insist on the DO and the students administering appropriate manipulation as a major part of the diagnosis and therapy.

And let all perform a good H & P, evaluate the inheritance, the life-style, the occupations, past and present, the social relationships, the diet and other factors, and consultants to share information about the whole person with each other. And above all, hold your head high, be proud, "unfurl your banner" that this is "osteopathy, the only complete, eclectic system for maintenance of health and healing the sick."

Letter to A.T. Still

Thank you, and I hope to talk with you again some day.

By this time, I was being sprayed by the surf from the tide rising to its 12-feet peak as the setting sun painted the palate of the sky with muted colors, the lobster boat was heading to port, and the usually raucous gulls were quietly flying to their resting areas.

And as I head for home, I continued to wonder how Dr. Still would really feel about and respond to the changes in health and health care in the 20th century. ❑

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The American Academy of Osteopathy
Phone: (317) 879-1881 or
FAX: (317) 879-0563

Dear Doctor Still,

Students often ask interesting questions about osteopathic manipulative techniques. Some questions seem to be asked more often than others. For example, students ask about the "pop" they often hear when performing osteopathic manipulation using high velocity low amplitude techniques. Where does the sound originate? What if we do the manipulation and don't hear a "pop"?

You must have heard the same questions when you were teaching students in the early days of osteopathic medicine. I base this statement on the fact that you addressed the subject in your book, *Osteopathy: Research and Practice.* On page 52 you said: "One asks, how must we pull a bone to replace it? I reply, pull it to its proper place and leave it there. One man advises you to pull all bones you attempt to set until they pop. That popping is no criterion to go by. Bones do not always pop when they go back to their proper places nor does it mean they are properly adjusted when they do pop. If you pull your finger you will hear a sudden noise. The sudden and forceful separation of the ends of the bones that form the joint causes a vacuum and the air entering from about the joint to fill the vacuum causes the explosive noise. That is all there is to the popping which is fraught with such significance to the patient who considers the attempts an adjustment have proven effectual. The osteopath should not encourage this idea in his patient as showing something accomplished."

One of your students, A. S. Hollis, DO, also had some interesting words on this topic. He, of course, was a professor of Osteopathic Principles at the American School of Osteopathy from 1912-1914. He wrote a book, *The Principles of Osteopathic Technique*, and on page 10 he said the following: "Many times in using manipulations a "pop" is heard between the articular surfaces. This is due to the separation of those surfaces and is not of supreme importance itself. In fact, the more strictly normal and articulation is, the more readily and frequently, it can be unpopped". In other words, if a pop can not readily be obtained between almost all the vertebrae, there are generally but two explanations possible. One is that the line of force used was not properly applied, and the other is that the tissues were so congested and the ligaments etc., so thickened that the force applied was insufficient to cause a separation of the articular surfaces. At this point we would simply mention the fact that too frequent popping or vertebral articulations (and especially of those in the neck) undoubtedly causes irritation and is itself productive of considerable harm; also in some people there is present so lax a condition of the connecting tissues that the vertebrae pop at the slightest provocation. Many osteopathic movements do not produce a "pop", and in these cases the force is applied directly in the line of the plane of the articulation and the principle employed is analogous to that employed in breaking up adhesions in one of the larger joints of the body."

These are all very interesting points. I suppose we may never know the full answer to these kinds of questions; but in the future, when someone asks me about "joint popping", I'll refer them to you and Doctor Hollis for more information.

Your ongoing student,
Raymond J. Hruby, DO, FAAO
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Manual Medicine and its Role in Psychiatry

Gerald G. Osborn, DO, M Phil, FACN

Editor's Note: Dr. Osborn is a 1973 graduate of Kirksville College of Osteopathic Medicine and is a fellow of the American College of Neuropsychiatrists. He is currently an Associate Professor of Psychiatry and Medicine Adjunct Professor of History at the Michigan State University/College of Osteopathic Medicine.

Abstract

Since its origination in the late 19th century, osteopathic medicine has been most closely associated with general practice. The theory which informs osteopathic medical education and practice lends itself more to the comprehensive language of the generalist than the reductionistic language of the specialist and the subspecialist. At worst, osteopathic principles have been omitted from the literature of specialty care, and at best, have been poorly articulated.

Psychiatry is no exception to this and because of the general proscription against touching patients, manual medicine has been ambivalently viewed by our specialty. This paper will attempt to explain how osteopathic theory in general, and manipulative treatment in specific, relate to the specialty of psychiatry.

Since osteopathic principles are integrated throughout, rather than merely "added onto" traditional medicine, this paper will argue they are equally applicable to specialty care as they are primary care.

Common Developmental Origins

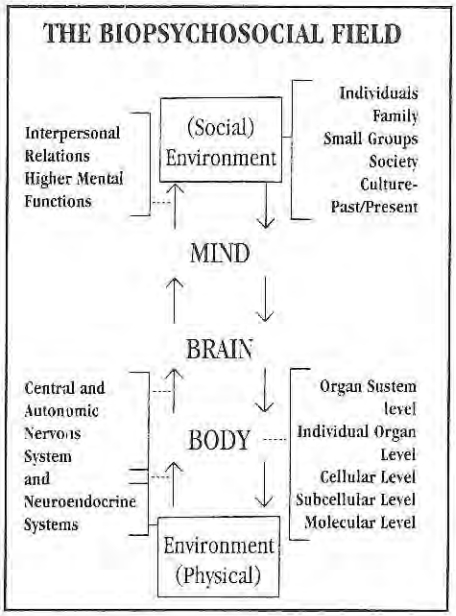
Psychiatry developed as a distinct specialty in the mid 19th century in Western Europe.[1] In the tradition of 19th century scientific reductionism, early psychiatrists were interested in how increasingly minute neuropathologic change in the brain translated clinically into abnormal thought, mood, and behavior.[2] It was this interest in the brain in general and the effect of disease on complex behavior and higher-order cognitive function in the specific which caused psychiatry to separate from neurology. Human behavior can be reduced to an analysis of the contraction of muscles and their affect upon the skeletal system, coordinated by the nervous system. This quantifiable analysis can be further extended to the contraction of cardiac and smooth muscle. In this context, the relationship of psychiatry to osteopathic philosophy ceases to be abstract. The coordinating role of the autonomic nervous system and its importance to the mediation of psychophysiologic disorders also provides a connection with osteopathic theory.[3]

Psychoanalysis like psychiatry had its origins from the specialty of neurology. Sigmund Freud, inspired primarily by Charcot and Breuer, attempted to create both a unified neuropsychological theory of psychic function and a novel method of clinical inquiry. In his studies of hysteria, he was trying to explain how the brain was capable of higher-order cognitive function while coordinating voluntary and involuntary processes and moderating primitive and emotional arousal. The primary aim of his endeavor, "The Project for a Scientific Psychology," was to create the ultimate integration of mind and brain. Psychoanalysis has always been criticized for its problems with quantifiability and the Project for a Scientific Psychology suffered the same difficulty. That there is a direct neural relationship to emotion and thought is theoretically unassailable, but by the standards of modern science, not completely provable. Because the technology did not exist to prove his theory, Freud ultimately abandoned "The Project", but it remained the theoretical basis for psychoanalysis and later the dynamically-oriented psychotherapies.[4]

The problems of quantifiability with the more dynamic psycho therapies have a close parallel in osteopathic manipulative treatment. There is a tremendous amount of historical, anecdotal and testimonial evidence that both are clinically effective. The existence of large scale, systematic, double-blind and placebo-controlled studies for both are also extremely scarce.

Osteopathic philosophy and dynamic psychotherapy share other

striking commonalities. Both involve the understanding of patients with a complex systems-approach. Both appreciate and approach the person with the illness at least equally with the illness the person has. Both also involve the interactional significance of the doctor/patient relationship and recognize the special therapeutic implications of communication. Where the commonalities begin to diverge is in the specific disorders in which they are most helpful. The therapeutic implications of osteopathic manipulative treatment are more profound because they go beyond traditional psychosomatic process. Although not being well suited to traditional reductionistic specificity, osteopathic theory has the most current biopsychosocial systems theory on its side.



The schema of the biopsychosocial field theory is completely consistent with osteopathic philosophy. Osteopathic physicians have a distinct and conceptual advantage in that osteopathic thinking has always considered the person in relation to his internal external environment. The appreciation of the self-regulatory mechanisms of the human organism from molecules to culture is inherent with the whole person systems-context of osteopathic medicine.

Psychiatry and Biopsychosocial Medicine

One of the most common characteristics of physicians who choose psychiatry is a broader interest in the complexities of health and illness. With this comes a better appreciation of the role behavior plays in making diagnoses. An obvious example of this would be flexed posture, psychomotor retardation, downcast facies and sighing respirations which constitute the generic behavioral tetrad of depressive disorders, in the case of major depression, added to these features are complex neurovegetative indicators, many of which are symptoms mediated by the autonomic nervous system. Radical behaviorists here may have an advantage over more dynamically-oriented psychiatrists. They would conceptualize the features of the above as the contraction of skeletal and smooth muscle and would agree these features represent valid and reliable characteristics to quantify severity of the illness and response to treatment.

Perhaps even more exemplary would be the phenomenon of anxiety. There is clear clinical and experimental evidence which demonstrates overall increase in muscular tension during periods of anxiety and stress-related emotional arousal. The various anxiety disorders are the most severe forms with generalized anxiety disorder even having markedly increased motor tension as a component of its diagnostic criteria. Since anxiety is a universal experience and a feature of nearly all psychiatric disorders, it is surprising more research has not been promoted by Osteopathic Psychiatry into neuromusculoskeletal features of the illnesses we treat. Most of the research has been by neurophysiologists and, therefore, more basic science oriented. However, some important clinical findings have been demonstrated.

The problems associated with doing this type of research are primarily the specificity of musculoskeletal response to anxiety-produced stimuli. One of the classic studies is dated but provided the preliminary basic of using muscular tension as a technique for studying emotional tendencies.[7] Not only did Duffey demonstrate that muscular tension increases in proportion to an increase in psychological stress, but muscular tension also spreads to involve increasingly larger areas of the body. Heath et.al. demonstrated that as anxiety increases, there is a tendency to lose discrete control of specific muscle groups.[8] Even with the tendency toward progressive generalized spread of muscle tension with increasing psychological arousal, patterns of tension show considerable variation between individuals. Data about specific patterns of muscle tension in specific psychiatric illnesses are not conclusive however. The muscle groups reflecting markedly increased tension associated with negative affect and especially anger are frontalis, temporalis, masseter, paracervicals, trapezius, biceps and quadriceps. A study of patients in 1972 demonstrated decreased postural reflex activity of the supraspinatus muscles.[9] This correlates well with the flexed posture ordinarily seen in depressive disorders. Musculoskeletal changes show a clear spectrum of abnormality with more mild changes in non-psychotic disorders and much more profound changes in the severely psychotic conditions. Studies have demon-

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strated both microscopic changes in the muscle tissue and elevated blood vessels of muscle tissue enzymes in a variety of acute psychoses.[10,11]

Many studies, usually in respect to rheumatoid disease, have tried without much success to link patterns of neuromusculoskeletal findings to specific personality types. Various psychological tests have been used both objective and statistical, such as the M.M.P.I. and the projective tests with conflicting results.[12,13,14] Because of the serious methodological flaws, the search for specific psychosomatic personality types, in this case, the "Rheumatoid Personality", has been almost completely abandoned. The major problem the early psychoanalytical theorists could not address was whether the abnormal M.M.P.I. and projective findings represented the straight-forward misery and disability that rheumatoid arthritis produces, rather than a pre-morbid personality type predisposing to the illness. It seems quite reasonable that muscular tension represents a final common pathway of behavioral expression to most psychiatric disorders. To scientifically determine whether specific patterns of muscular tension represent specific feeling states or even specific diagnoses will require much more sophisticated and systematic research.

Equally interesting but likewise equally baffling is the affect of emotional arousal on trophic and secretory functions associated with the autonomic nervous system. It is plausible that there are connections here with the complex clinical manifestations of the somatoform disorders. They also probably account for the dramatic somatic components of disorders like major depression, panic or even catatonic states.

It is clear that many opportunities await thoughtful and systematic clinical research into the relationship of musculoskeletal findings to psychiatric illness.

Oken (1975) has suggested some general conclusions about the research findings already compiled.

1. There is a tendency for individuals to be characterized by different levels of muscle tension and to maintain this relative level in various situations. Perhaps the best personality correlate of higher tension is the tendency to experience anxiety and to manifest other forms of emotional hyper-reactivity.

2. Individuals have a proclivity to develop tension, when stimulated, primarily in specific sites characteristic for themselves. Under conditions of increased arousal, tension tends to become progressively more generalized, and the differences among individuals thus tend to disappear.

Touch is the most primal form of human communication with the capacity to both heal and harm

3. Under stressful conditions, particularly those which induce anxiety, muscle tension rises. At high levels this increase in response is likely to be accompanied by its prolongation in time, and by its spread, leading to disruption of motor coordination. The relationship of stress-induced tension with heightened anxiety is clearest, but it may be related also to anger and other affects, to the mobilization of certain defenses, to the state of conflict or frustration, or to all of these.

4. Patients with psychiatric disorders of every type are likely to exhibit high levels of muscle tension, especially after stressful stimulation. It is uncertain if this relates to the disorders themselves or is merely a reflection of anxiety and the other factors just mentioned. Increased tension may be especially characteristic of two disorders, schizophrenia and the depressions, above, and beyond the presence of anxiety. For the depressions, where the evidence seems particularly strong, the level of tension seems to parallel the severity of the disorder, even in the presence of overt psychomotor retardation.

5. No convincing evidence yet exists to related specific patterns or sites of muscle tension to specific affect states or to specific psychiatric diagnostic entities, despite several interesting suggestions. This state of knowledge may be partly a product of the fact that few studies have obtained tension measure from more than a limited number of sites.

6. Clarification of many of these problems seems amenable to research embodying now existing technical and methodological knowledge.[15]

Manual Medicine in Psychiatric Treatment

In theory there are many commonalities in the principles of osteopathic philosophy and treatment and the biopsychosocial paradigm of modern psychiatry. Many controversies arise, however, when translating theory into practice. A particularly complex problem is the use of manipulative treatment performed by the psychiatrist.

Transference and counter-transference are central communication issues in the most

psychotherapies. Many would argue they are issues in all forms of treatment. Language is the most sophisticated form of communication and constitutes the basis of psychotherapy. But language clearly does not account for all of the communication which transpires between physician and patient. A great deal of research exists abut the power of nonverbal communication. Even subtle and seemingly innocuous gestures and body movements can have profound meaning. A large component of psychotherapy training is learning to become an exquisitely sensitive observer of human behavior. Most non-conflictual human communication is characterized by congruity of thought content, affect and behavior. Therapists are trained specifically to carefully assess nuances of behavior which communicate conflict through incongruency, i.e., hand wringing and sighing which render and otherwise warm smile unconvincing. Even though most psychotherapy texts cover mainly verbal communication, most include a significant space to nonverbal behavior. Some even deal with unraveling the most subtle nuance of posture, gesture and facial expression.[16]

Touch is the most primal form of human communication with the capacity to both heal and harm. Because of its generic nature, touch has also the capacity to be easily misinterpreted. Since many of the psychiatric disorders involve a tendency to distort and misinterpret, it is extremely important to make all communication as clear and unambiguous as possible. The tendency to distort usually has its origins in some form of developmental trauma which damages trust. Granting permission to touch implies a level of trust many psychiatric patients simply do not possess. It follows then that the more profoundly basic trust is damaged, the more likely touch will be poorly perceived on the part of the patient, even when that touch is given with the kindest of intentions.

The unique nature of the psychiatrist-patient relationship is so different from that of the other medical specialties that the issue of touch in psychiatric care merits extraordinary reflection. A reassuring pat on the shoulder by a family physician or another specialist could be very unwise on the part of the psychiatrist. Even non-psychiatric physicians, however, are now being trained on the more subtle aspects of human communication in their basic interviewing courses.[17,18]

Since there is the possibility of compromised communication between psychiatrist and patient even in the less severe and disabling psychiatric disorders, it is almost always better to err on the side of safety and clarity by referring patients to manipulative treatment rather than providing it ourselves. It is therefore important to be acknowledgeable about disorders where manipulative treatment may be a helpful adjunct.

Specific Disorders

As discussed earlier, the psychiatric disorders where manipulative treatment may be a helpful adjunct are the anxiety and somatoform disorders. Muscular tension is a universal finding in the anxiety disorders ranging from mildly annoying and uncomfortable to being a disability symptom. In the comprehensive treatment plan of dietary advice, aerobic exercise, relaxation, psychotherapy and judicious use of medications, manipulative treatment can be extremely helpful. This is especially true for those patients suffering from generalized anxiety disorder and those in the anticipatory innerpanic phases of panic disorder. With the concomitant decrease in muscular tension, it is at least theoretically plausible that patients with generalized anxiety disorder may be able to function with lower doses of medication and perhaps without medication altogether.

After the diagnosis of a somatoform disorder is confirmed, treatment generally follows a program of continuity of conservative care rather than cure. One of the most important features of this continuity of care is establishing a solid physician-patient relationship which is best served in the primary care-ambulatory setting. This is the most preventive approach to control the continual search by the patient for the specialist with "the answer" to their somatic concerns. The major risk for these patients is potential complication from yet another invasive procedure which yields at best equivocal findings insufficient to explain the severity of their symptoms. Using manipulative treatment as an adjunct to the comprehensive management program adds an important conservative low-risk modality. It not only attenuates the patients' somatic symptoms but the "laying on of hands" by the physician communicates care which attenuate the central emotional need these patients so desperately feel. Manipulative treatment may communicate the necessary reassurance that the patient with somatization, hypochondriasis or even somatoform pain disorder, needs to prevent another trip to the hospital emergency department or the office of one more surgical subspecialist. It is the author's experience on a busy Consultation-Liaison Psychiatry Teaching Service, that patients with somatoform disorders referred for manipulative treatment show a dramatic decrease in crises and subsequent hospitalizations. This

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clearly has implications for effect cost-containment as well as improvement in overall patient functioning.

Equally important to the application of any treatment modality is understanding when it is contraindicated and manipulative treatment is no exception. Psychiatric disorders where basic trust is severely compromised or reality-testing impaired are obvious conditions where manipulative treatment is contraindicated. The prototype disorder here would be schizophrenia of the paranoid type but contraindications extend to the spectrum of psychiatric disorders, from Axis-II to a specific anxiety disorder. Many personality disorders have a predisposition to distort and misinterpret the clearest of communication. Patients with Histrionic or Borderline Personality would have a high likelihood to experience manipulative treatment in sexualized or even assaultive manner. In the anxiety disorder group, the patients who would require most caution are those with Post-Traumatic-Stress Disorder (PSTD). Many practitioners of manipulative treatment have anecdotally reported some patients experiencing seemingly unexpected strong affect during a procedure. In PSTD, patients may have an intrusive memory heightened or experience an abjectly terrifying flashback of a traumatic event. This would be especially likely if the PSTD is secondary to an assault, either recent or remote.

Making the best referral for manipulative treatment can also be complex. It requires careful discussion with the patient, an assessment of psychological conflicts and an explanation of benefits vs. risks. Equally important are the personality characteristics of the physician to whom the patient is referred. Some issues are straight forward, others extremely complicated. An example of the former would be a young woman with delayed symptoms of PSTD secondary to ongoing sexual abuse by her father. If manipulative treatment were considered at all, the more closely the practitioner resembled her father, the more risky the treatment, i.e., more likely to heighten anxiety or generate flashbacks. When manipulative treatment is considered, a physician who is insightful, psychologically sophisticated and experienced with the general medical treatment of psychiatric patients, is the most valuable referral resource.

With the increasing dissatisfaction of the public with "high-tech, low-touch" health care, and the promotion of the biopsychosocial approach to medical education, osteopathic physicians are especially poised to demonstrate the effectiveness of manual medicine.

Summary

Manipulative treatment although controversial as an adjunct to the care of patients with psychiatric disorders, nevertheless deserves much more careful consideration than it has received in the past. In general, any psychiatric disorder characterized by increased muscular tension regardless of its etiology, and with basic trust and reality-testing intact could be a condition where manipulative treatment is indicated. The anxiety and somatoform disorders provide clear examples where manipulative treatment can be very helpful. Schizophrenic disorder of the paranoid type and paranoid personality disorder are clear examples of contraindications. It is arguable that under certain circumstances the treating of psychiatrist could perform the manipulative treatment. In most circumstances where manipulative treatment is considered however, the patient should be referred with special attention paid to the skills and characteristics of the physician providing this modality.

As well as providing extended and sophisticated care to well-selected patients, manipulative treatment provides an opportunity for some exciting clinical research. Examples would be comparative studies of the efficacy with standard treatment and with the addition of manipulative treatment. The implications for studies in cost-effectiveness compared to traditional treatments are also of particular interest in these times of escalating health care expenditures.

With the increasing dissatisfaction of the public with "high-tech, low-touch" heath care, and the promotion of the biopsychosocial approach to medical education, osteopathic physicians are especially posed to demonstrate effectiveness of manual medicine. The basic concepts of osteopathic medicine are alive, well, and as applicable to modern specialty practice as they were to the late 19th century general practice in which they originated.

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[Reprinted with permission from the Journal of the American College of Neuropsychiatrists, Spring, 1993.]

Message from the UAAO Chair

Osteopathic Medicine: An Expanding Profession

Anita W. Eisenhart
PCOM '94

While statistics and political trends have never been a forte of mine, I do have an interesting fact to share. During the past year, the number of osteopathic medical schools in Pennsylvania has doubled while the number of allopathic schools in the state has decreased by one.

The class of 1997 is well under way at the new Lake Erie College of Osteopathic Medicine (LECOM). They are 60+ students strong and look forward to growing in the near future.

I recently visited the LECOM campus and was greeted by a very dynamic, exciting group of students. They are proud of their new-found profession and look forward to learning their trade with great fervor.

UAAO was invited on campus by LECOM's Dean, Dr. Sylvia Ferretti. Dr. Ferretti is a physiatrist by training and a strong supporter of osteopathic principles, practices and teachings.

LECOM had a very distinguished visitor last January. Amidst airport and road closings, Dr. Herbert Yates, president of the American Academy of Osteopathy, traveled through many feet of snow to Erie, Pennsylvania. Rumor has it, Dr. Yates arrived on campus with a dog sled team and several layers of ice and snow dripping for his Grizzly Adams-like beard!

Dr. Yates led a two-day workshop on myofascial techniques. He was joined by students of the Ohio UAAO chapter. Of note, Imber Corcoron, UAAO Region II Leader, was on hand to help the LECOM students develop their own UAAO chapter.

Dr. Yates inspired and encouraged the students of Lake Erie. Even though the two days of the workshop were long, the students wanted more! A few of the LECOM students are trying to scrape together the money to go to Convocation in Colorado Springs. They hope to drink in as much of the Academy and of osteopathic teachings as possible.

Several other Academy members are scheduled to give workshops in Erie. These include Drs. Walter Ehrenfeuchter, Alexander Nicholas and Anthony Chila. Plans are in the works for additional visits.

LECOM is the sixteenth osteopathic medical school to open their doors. Will there be more? Most certainly. There are two, perhaps even three, more schools on the drafting boards.

Of course there are many osteopathic physicians that believe we should spend more time, money and effort to improve the schools we already have. Are we spreading ourselves too thin? Are we trying too hard to grow in numbers instead of improving the quality of an osteopathic education?

While these are certainly valid concerns, I am excited to see our profession grow. I hope to someday be an integral component in the growth of our profession.

As for the 'quality' of an osteopathic education, I can only speak for myself. In a few weeks, I, too, will be a DO. I am very proud of my undergraduate education. I feel confident that my training to date has been strong and look forward to an exciting postgraduate osteopathic training program.

Although there is always room for improvement, I do not think improving the osteopathic education in this country should include stunting the growth of osteopathic medicine. It is exciting to know that in 1997 there will be about 300 new osteopathic physicians in Pennsylvania alone!

In 1991 Charles E. Still, Jr., DO, published a biography of his grandfather, Dr. Andrew Taylor Still. In it, he describes his grandfather comparing osteopathy to "a squirrel in a tree with his tail sticking out and most of his body still in he treet waiting to be pulled out." While we are still discovering the intricacies of osteopathic principles...still pulling out the rest of that squirrel...we can grow. After all, the more DOs we have tugging on that squirrel, the better chance we have of freeing the little critter and all of the osteopathic secrets it possesses.

Opportunities and Issues for Osteopathic Hospitals

Editor's note: *This survey points out a number of issues regarding the use of osteopathic manipulation in the hospital setting. These issues, and some of the important points surrounding them, were presented by Laurie Jones, Mark S. Cantieri, DO and Raymond J. Hruby, DO, FAAO at the Annual Conference of the College of Osteopathic Healthcare Executives/Association of Osteopathic Directors of Medical Education (COHE/AODME) in May, 1993. The issues presented were as follows:*

A survey of 110 osteopathic hospitals was recently conducted by the American Academy of Osteopathy, with 63 hospitals responding. Perhaps the most significant finding was that while 83 percent of all patients entering an osteopathic hospital receive a structural exam, fewer than 12 percent receive any form of osteopathic manipulative medicine. This means that nearly nine out of ten patients entering osteopathic hospitals receive no osteopathic manipulation at all.

1. **Quality Management Issue:** This is a quality management issue for two obvious reasons. The first is that according to AOA Accreditation Standards, 100 percent of all patients entering an osteopathic hospital should receive a structural exam. The survey revealed that 17 percent of all osteopathic hospitals are not in compliance with this minimum requirement.

The larger quality management issue is that conservatively speaking, between 38-50 percent of all patients entering a hospital have some somatic dysfunction. This was determined by a sampling done by Richard Feely, DO, at a large osteopathic hospital. Of the more than 2,000 charts reviewed by Dr. Feely, nearly 50 percent showed clear signs of somatic dysfunction. Yet fewer than 2 percent of those 2,000 patients received any osteopathic manipulative relief.

2. **Fiscal Oversite Issue:** Mark S. Cantieri, DO, did a retrospective survey of 40 charts at a osteopathic community hospital. He reviewed charts that called for OMM and compared them to charts showing that OMM was actually delivered to the patient. He found that while 15 cases of OMM were called for, only 4 patients received OMM. Based on a conservative estimate of 3 treatments received at $50 per treatment, the total revenue generated from those charts should have been $2,250. It was, however, only $600. This represented a loss of $1,650 from a sampling of only 40 patients.

Extrapolating out this number based on the total admissions for the year, Dr. Cantieri estimates that this hospital is losing $186,150 per year by not providing OMM to all patients who actually need it. In his report to the AOHA, Dr. Cantieri states "If the third quarter of 1992 is a representative sample, and if all 3,267 admissions were evaluated for OMM indications, we could assume that in 38 percent of the patients OMM would be indicated. That would be 1,241 patients. If all patients were given OMM treatments times 3 at $50 per treatment, the potential revenue for the hospital would be $186,150."

3. **Preventive Healing.** OMT works. By adding this modality to the already extensive weaponry of traditional invasive and pharmacological remedies, patients will be getting better, and more total care, in an osteopathic setting.

4. **Moral Integrity.** While students, taxpayers and patients are told by the osteopathic profession that there is a reason for having two distinct schools of thought and practice within the medical arena, there are currently few tangible, recognizable differences. Students want to be taught OMT. Patients want to receive OMT. Yet osteopathic hospitals are not delivering it. The impression is that the very institutions designed to promote and deliver this "different kind of health care" do not perceive a difference themselves. OMT is the only visible, tangible activity that emphasizes the philosophic differences between the osteopathic and allopathic professions.

5. **Timing in the marketplace.** *USA Today* and *Time Magazine* recently reported that the number of people seeking alternative medical therapies far exceeds what anyone previously estimated. In a survey conducted by the Gallup Corporation for *Time Magazine*, nearly one in three Americans had sought alternative care within the last 6

→

weeks, and 86 percent of those would return. Americans spent nearly as much on straight fees to alternative practitioners as they did on out of pocket fees to traditional practitioners. Clearly, the demand for new ways of treating and touching people is there. And in the words of Herb Yates, DO, President of the American Academy of Osteopathy, "Osteopathy is the only bridge between traditional and alternative medicine."

From a marketing standpoint, having osteopathic hospitals deliver OMT to patients in a hospital setting will allow a marketing niche and edge that other hospitals cannot deliver.

6. Management Care Advantage: Edward D. Stiles, DO, conducted a retrospective study of charts from four disease groups. He looked at those who had received OMT and compared them to those who had not received OMT from four disease groups at Waterville Hospital in Maine. His findings are shown above.

Although the study was done in 1979, the implications still remain. If these percentages were figured in today's dollars, assuming an average hospital day costs $1,000, then OMT could represent a savings of between $70 to $140 per patient. By billing for the service at an average billing of $150 per patient, the combined revenue benefits from OMT could equal between $220 to $290 per patient.

LENGTH OF STAY FOR EACH DISEASE

Diagnosis Reduction	Non-OMT Group	OMT Group	%
Chronic Obstructive Lung Disease	5.0 days	4.3 days	12 %
Pediatric-lower Respiratory Tract Infections	5.4 days	4.9 days	9 %
Cholecystectomies	8.65 days	8.0 days	7 %
Hysterectomies	9.1 days	8.0 days	14%

TABLE 1

CONSUMERS WANT DOs

Following is a breakdown of requests for osteopaths received PER DAY in the following cities, based on a Consumer Health Reports survey of 825,000 calls received over a one-year period. The request for an osteopath was the fifth highest ranking request of all received from people seeking a general practitioner.

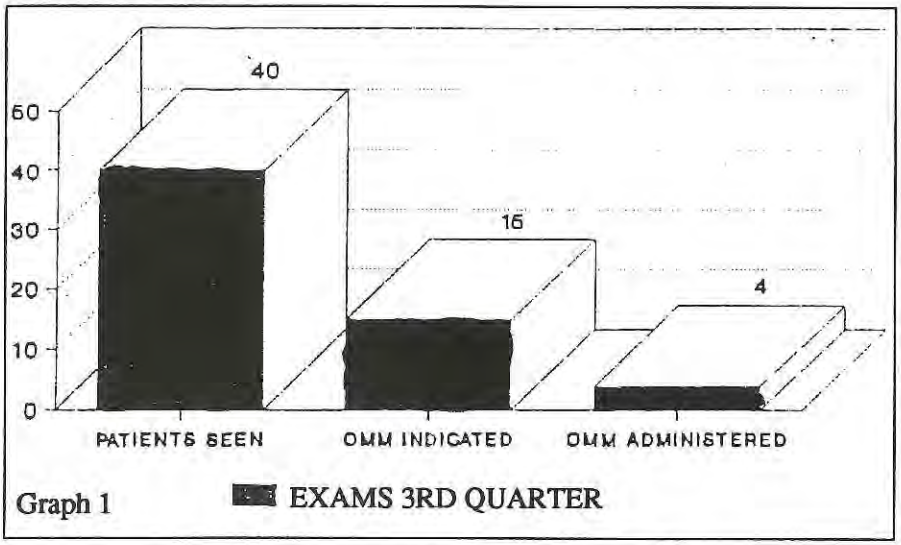
City	Requests for DOs Yearly	Monthly	Daily
Chicago	19,386	1,653	54
Washington, DC	16,530	1,377	45
Dallas/Fort Worth	27,274	2,272	74
Denver	51,243	4,270	140
Houston	10,744	895	92
Milwaukee	32,233	2,686	88
Philadelphia	38,845	3,237	106
Totals	230,141	19,213	628

Correction

In the article, *A description of the Common Compensatory Pattern in Relationship to the Osteopathic Postural Examination* by Guy A. DeFeo, DO and Laurence V. Hicks, DC, page 18-23 of the December 1993 issue of the *The Journal of the AAO*, we were remiss in not acknowledging the sources for Figures 1, 5, 6, 10 and 11. Our apologies to the authors.

Figures 1, 5, 10, 11
Physical Examination of the Spine and Extremities
Stanley Hoppenfeld, MD
Published by Appleton, Century, Crofts; New York

Figure 6
Glossary of Osteopathic Terminology
American Osteopathic Association
AOA Directory, 1992



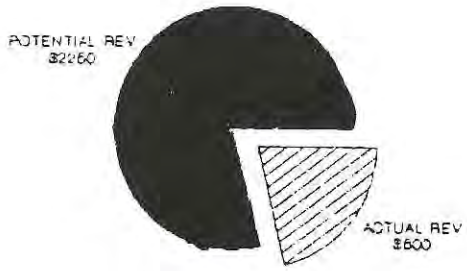
Graph 1

Community Hospital OMM Study

Graph #1 - This graph represents the number of charts reviewed during the third quarter of 1992 (n=40)

Of the 40 cases reviewed, there were 15 cases in which OMM was evaluated to be indicated.

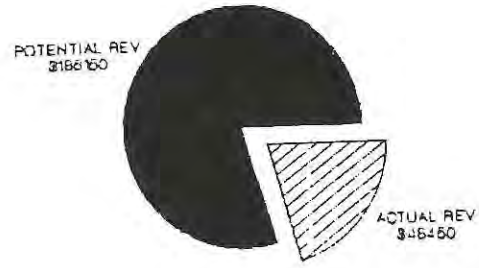
Of the 15 cases where OMM was indicated, 4 patients actually received OMM.



ACTUAL VS. POTENTIAL REVENUE 3RD QUARTER
Graph 2

Graph #2 - Given the assumption that if OMM is given, the patient will received an average of 3 treatments at a charge of $50 per treatment, if all 15 cases where OMM was evaluated to be indicated had received treatment the revenue would have been $2,250.

The graph demonstrates that since only 4 of the 15 patients actually received OMM, the revenue should be $600.



Graph 3 POTENTIAL ANNUAL REVENUE

Graph #3 - The third graph is an assumption based on the actual number of admissions in 1992. (3,267 admissions)

If the third quarter of 1992 is a representative sample, and if all 3,267 admissions were evaluated for OMM indications, we could assume that in 38 percent of the patients OMM would be indicated. That would be 1,241 patients.

If all 1,241 patient were given OMM treatments times 3 at $50 per treatment, the potential revenue would be $186,150.

If only 26 percent of those patients received OMM (the same percentage as those receiving OMM in the third quarter of 1992) the actual revenue would be approximately $48,450.

Response

As a result of the Academy's presentation, 7 osteopathic hospital CEO's (out of 13 hospital CEOs attending) immediately responded to the offer of assistance from the American Academy of Osteopathy.

Twenty-six hospitals responded positively to the survey, asking for assistance from the Academy with setting up an OMM Department, coding and billing, quality management issues and recruiting an OMM Director.

For more information about how the AAO can assist with increasing the delivery of OMM in your hospital, call (317) 879-1881.

An Osteopathic Approach to Treating Chondromalacia-Patellae with Counterstrain Manipulation

by Jerry L. Haman, DO

Editor's Note: *Dr. Haman is currently on the faculty in the OMM Department of Kirksville College of Osteopathic Medicine. He is certified in family practice.*

As we realize the importance of aerobic exercise in the reduction of cardio-vascular events the general populace has taken up exercise as a regular habit. With this increased incidence of exercise I have seen an increase in the amount of chondromalacia-patellaw in my practice. Cailliet[1] states that this type of soft tissue knee pain is probably caused by repetitive minor trauma. Often there will be arthralgia of the knee without x-ray changes. Many of these patients can be helped by manipulation, often decreasing the need for surgery.

The technique for the release of the patella is a simple one using indirect counterstrain techniques advocated by Lawrence Jones, DO, FAAO[2], and Harold Schwartz DO, FAAO[3]. If the physician will move the patella medically or laterally, he or she will find usually that the patella will move one way more easily than the other (Figure 1).

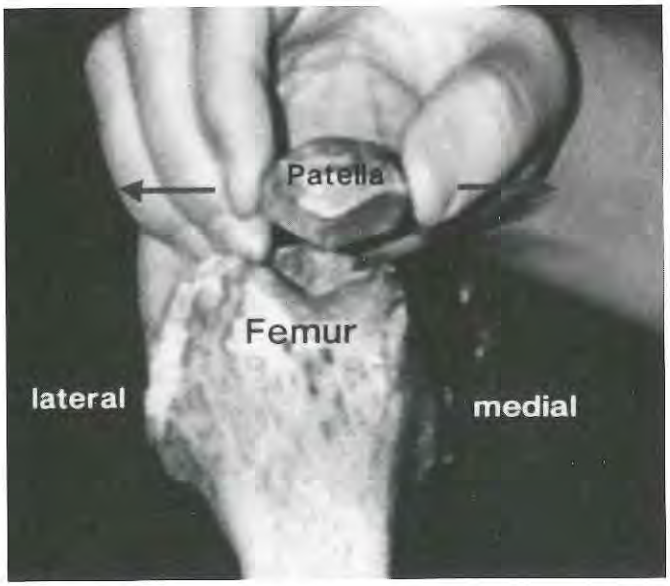


Figure 1. Motion test: Medial and lateral movement of the patella with the patient supine and the knee at rest.

This is a sign of somatic dysfunction, or decreased motion; the patella should mnove equally in both directions in my experience, This inequality of motion means that the patella will not ride in the midline of the patellar surface of the femur, causing a greater pressure on one side of the patella and greater wear and tear on that joint surface (Figure 2).

Figure 2. If motion is easier or less restricted medially then the fascia around the knee is too tight and will cause excess wear and tear on the medial portion of the patella and patellar surface of the femur, ie; chondromalacia-patellae.This leads to clinical entity of chondromalacia-patellae.

This problem often can be resolved without surgery by counterstrain manipulation of the patella. If you look for a hot or cold spot on the medial or lateral aspect of the patella, you many find a tender point in the middle of the hot or cold spot (4) (figures 3 and 4).

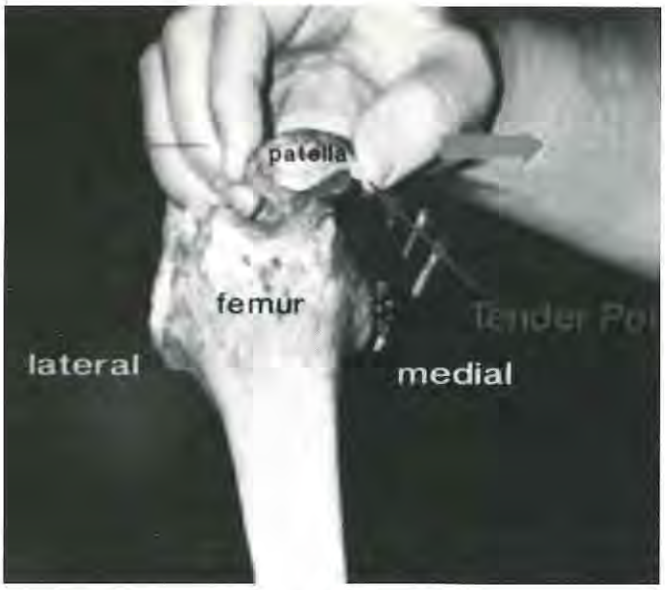


Figure 3. In this example the motion of the patella is better medially. There should also be a tender point on the medial side of the patella. Move the patella around the tender point (medial) until there is no pain when the tender point is pressed, and then hold that position for 90 seconds.

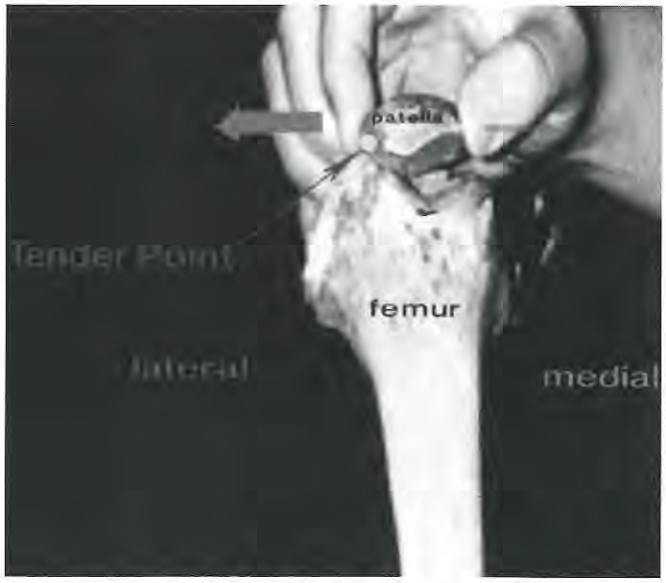


Figure 4. Likewise, if the motion is better laterally the tender point will be on the lateral side of the patella.

Finding a tender point on the side of the patella that moves the easiest and moving the patella the way it moves the easiest will remove the pain at the counterstrain point. Hold this position for 90 seconds. This will also release the fascia around the knee that is pressing the patella into the patellar surface of the femur. In other words the pressure that causes the disease entity, or effect called chondromalacia-patellae is easily removed with indirect techniques.

If you can not find a tender point just take the patella the way it is looser, or moves the easiest, medial or lateral and wait 90 seconds. You will get similar results.

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A.T. Still Medallion Deadline Nears

Please remember that if you wish to submit the name of a candidate for the 1994 A.T. Still Medallion of Honor Award, the deadline is April 15, 1994.

Deserving members of the Academy who shall have exhibited among other accomplishments in scientific or professional affairs an exceptional understanding and application of osteopathic principles, and of the concepts which are the outgrowth of those principles, may be awarded the Andrew Taylor Still Medallion of Honor. The Academy cherishes this award as its highest honor, and all petitions are considered confidential.

If you have any questions or need any additional information about this procedure, please contact the Academy office or refer to page 109 of your 1993 AAO Directory.

From the AOBSPOMM Files

AAO Case History

William W. Lemley, DO

Editor's Note: *Dr. Lemley, of Lewisburg, West Virginia is a 1976 graduate of Kansas City College of Osteopathic Medicine and is board certified both in osteopathic manipulative medicine and family practice.*

PRESENT ILLNESS: This 25 year-old white male was first seen in the office on October 10, 1991, complaining of severe low back pain which began at work on October 8, 1991, while working for a moving company in Covington, Virginia.

The patient says that he was sliding a fiberglass board that weighed about 100 pounds when he felt a popping sensation in his back. He had immediate, sharp pain in the left lumbosacral region radiating to the left posterior thigh with no pain below the knee and no paresthesias in the legs. He had felt a similar pop in his back about 3 weeks prior to this visit while he was at work and lifting a 300-pound truck tire. He said that he fell down due to the severity of the pain, but continued to work and did not seek medical attention. His back pain slowly resolved. After the injury of October 8, 1991, he continued to work doing some lifting, but his pain became severe around noon the day before his office visit and he had to stop work then.

MEDICAL HISTORY: Essentially noncontributory.

SURGICAL HISTORY: None.

INJURIES: The patient admits to numerous back injuries in the past. A piano fell on him about 1989 resulting in "torn ligaments" in the left thigh. Apparently no x-rays were taken, and that injury resolved with no residual leg weakness. He has also had three or four strains in the past. He strained his right shoulder within the previous three weeks playing basketball and had some ultrasound treatment at a local physician's office with resolution of his shoulder pain.

SOCIAL HISTORY: The patient is a non-smoker and denies alcohol consumption or the use of recreational drugs. He works for a local moving company. His sleep pattern has been poor over the past several nights due to his back pain.

MEDICATIONS: None.

ALLERGIES: He is allergic to penicillin.

PHYSICAL EXAMINATION: The patient walked with an antalgic gait favoring the left leg. His blood pressure was 100/76. Standing examination showed the shoulders to be level. The left iliac crest was superior, popliteal folds were level and leg length appeared equal. Lumbar range of motion revealed that he experienced pain with flexion of fingertips to knee level; sidebending was normal; extension was painful.

There was segmental restriction and somatic dysfunction noted in the following areas: Moderate myospasm and exquisite tenderness at L5 on the left; left sacroiliac region; left piriformis; Jones' tenderpoints for lower pole L5 left; left mid pole sacroiliac; posterior ilium on the left.

There were no motor deficits to the lower extremities. He could heel

and toe walk without difficulty. There was no extensor halluces weakness. Patellar and Achilles deep tendon reflexes were +2/4 bilaterally. Seated straight leg raising was negative. Supine straight leg raising produced back pain only at 80 degrees on the left. FABRE and Romberg tests were negative.

IMPRESSION: Acute lumbosacral strain; somatic dysfunctions of the lumbar, sacral and pelvic regions.

The patient was given OMT in the forms of strain/counterstrain and myofascial release techniques including the use of the percussion vibrator. He noted some decrease in back pain following that treatment and his gait appeared less antalgic. He was placed on Dolobid 500 mg b.i.d. and Vistaril 25 mg cap 1 or 2 h.s. An x-ray of the lumbar spine was obtained and was normal.

The patient called the office on October 15, 1991, saying that he was noting some significant improvement and was wanting to return to light duty work which he was allowed to do on this date.

The patient was next seen in the office on October 17, 1991, and stated that he was feeling much better. Since he had returned to light duty work, he had had no increase in his back pain. He had stopped taking Dolobid and Vistaril and was obtaining relief of this backache with over-the-counter Ibuprofen. On physical examination, he could flex fingertips to the floor without difficulty; sidebending was normal. There was very mild lumbar myospasm at L3 and L4 bilaterally with no tenderness over the sacroiliac joints as previously noted. His final diagnosis was acute lumbosacral strain - resolving, and lumbar somatic dysfunction. He was given OMT in the form of lumbar mobilization and was instructed to continue his over-the-counter ibuprofen as needed. He was to continue light duty work through October 20, 1991, and then resume full duty on October 21, 1991. He was instructed to return to the office if further problems occurred and has not been since that last visit. ❑

From the Archives

Osteopathy — How it Differs from Other Manual Methods

from Osteopathy, the Science of Healing by Adjustment
Pearcy H. Woodall, MD, DO

In the minds of some otherwise well-informed people, osteopathy is occasionally confused with massage, Swedish movements, physical culture, exercise or even simple rubbing. The medical profession particularly appears confused as to what the practice of osteopathy is. They often labor under the delusion that massage and osteopathy are very similar, if not identical. This depreciating idea can issue only from an utter ignorance of the cardinal principles of osteopathy or from a very superficial knowledge of massage.

The means of treatment just alluded to are each of value under contributing conditions, but between them and osteopathy there is little similarity either in principle or practice. Osteopathic physicians may make use of them as aids or adjuncts, as would also the medical practitioners; but these adjuncts bear no more distinctive or significant a relation to osteopathy than they do to the practice of medicine. It might as well be claimed that they constitute the practice of medicine, as to say that they are the same as osteopathy. It can not be too strongly asserted or impressed that osteopathy is a complete **system** or science of treatment, while these other manual methods are merely small parts of a system, mere adjuncts or supplements.

Massage in some form has been practiced by all ancient peoples; it had reached advanced stage of perfection as early as the days of Hippocrates. It consists of a series of routine rubbings, strokings, tappings and kneadings, executed in a general and very indefinite manner. It is such work as is delegated to nurses and does not demand special knowledge of the body or of diseases.

Swedish movements were introduced in 1814 and they consist of little more than systematized exercises. Physical culture was practiced by the ancient Greeks and is merely the application of certain exercises for physical development. Ordinary exercise, judiciously prescribed, is of great value, to be sure, under approximately normal conditions; but it would be verging on the criminal to recommend it to patients acutely ill of pneumonia or typhoid fever or meningitis. In the presence of these critical conditions, osteopathy is invaluable, indispensable.

The fundamental fact in the conception of osteopathy is **adjustment**. Any method which does not embrace this principle is not osteopathy. Neither massage, nor Swedish movements, nor physical culture, nor simple exercises have even a remote suggestion toward correcting maladjustments of the body structure. This fact places them in an entirely different class from osteopathy.

To the end of properly adjusting the human machine when any of its parts are deranged and disease is present, the osteopathic physician must possess an intimate knowledge of its structure. An intimate knowledge of the skeleton—its every bone, its individual peculiarities, its relation to very other bone to which it is joined and to the body as a whole—a deep comprehension of the blood vessels — their devious course and their ultimate minute ramifications and the parts or organs to which they are distributed; a mastery of the nerves — from their centers in the cord and brain to the most distant cell over whose function they preside; a wide understanding of all the organs of the body, — their location and structure, as well as the evidences of their normal activity or symptoms of their disturbances — these are the *sine qua non* of the equipment of the osteopath. No surgeon needs to know anatomy more thoroughly than does the osteopathic physician. His knowledge of anatomy is his chart and compass and his cures will register in proportion to his ability to recognize and correct deranged anatomical conditions. He must only only be able to perceive the

location of the maladjustment, he must know how it is misplaced to be able to interpret its effects, and to bring definite mechanical principles to bear in replacing it. Since every moveable joint in the body is liable to misplacement, it is obvious that there can be a great range of maladjustments, both as to their location and character. Consequently there can be no such thing as routine treatment. Each case must be diagnosed and treated according to the causative condition present, and peculiar mechanical principles of treatment will apply to that particular case alone. The manipulative skill required of the osteopathic physician must exceed that of the surgeon. Not only the large joints, but every joint in the body, no matter how deeply hidden beneath masses of muscles and tendons or how obscurely located, must be subject to the osteopath's deft hands. His sense of touch must be delicately educated so that no variation from the normal in position or consistence of tissues can escape his notice. He must possess the delicate touch of the blind, not that he may read raised print which to the ordinary touch is meaningless, but to the end that he may read, to the minutest deviation from the normal, the structures of the body.

No time limit can be set upon the length of osteopathic treatment because in no two cases are the abnormalities the same. In one case the adjustment may be accomplished in a moment; in another case several minutes of preliminary relaxing treatment may be required before adjustment can be made. It may be said, with reasonable modifications, that the less time in which the adjustment can be made, the more skillful will be the treatment and the better the results. The advice of Dr. Still was to "find it, fix it and leave it alone". This is the keynote of an osteopathic treatment.

There is no knowledge or skill of value possessed by any other school of healing that is not utilized by the doctor of osteopathy. The adjuncts or aids have their sphere of usefulness but they are not osteopathy nor are masseurs and other practitioners of manual methods osteopaths. A stone mason is a useful member of society, but is not a sculptor; a house painter does a good service, but he is not a Raphael; the engine wiper who keeps the engine rubbed and polished is doing well, but he is not adjusting its deranged parts. So the practitioners of these adjunctive methods are each good in their sphere, but they no more approach osteopathy than does stonecutting resemble sculpture, or house-painting, portraiture or engine-wiping, engineering. ❑

To The Editor

Continued from page 7

that click, and heavy-force, high-impact techniques that left me feeling more abused than treated.

Back in the days of the 160 mile option, my youngest son was opened up from sternum to pelvis by an MD in an emergency situation, because I put off the 160 mile trip too long. A week or two previous to the surgery he had been jumping from post to post in the school yard, had fallen and taken the impact of his own weight on the top of the post to the lower end of his sternum. The somatic disfunction caused was intermittent, but was finally so severe that the visceral reflex shut down the peristaltic movement of 18 inches of his small intestine. The MD "milked" the backed-up food on through, sewed him up and swore up and down that the apple the kid had eaten the day of the surgery was the cause of the whole affair. When we got him out of the hospital, we took the trip. I don't know what I would do if such a thing happened now.

I have learned to handle my own problems somewhat less than satisfactorily on a stair tread, the edge of a table, a roll of newspaper, a folded towel or someone's fist. I have learned that my colds are more severe, my flu lasts longer and my blood pressure is somewhat less stable than when I could get an OMT every few moths. I have learned to endure and watch my family endure more pain than I know is necessary. So far, we have survived, but I still don't know what to tell my coworkers who are in pain and/or headed for spinal surgery. I refuse to bad mouth an honorable profession, a few members of which have sufficient integrity to do what they know is best, least invasive and least expensive in time, pain, and money for their patients. What do I tell them? Any suggestions?

I wish there were some way to separate the ones who are really committed to exercising the finest of what Osteopathy is all about from the others at graduation. Perhaps it would help to award the PP degree for those whose desire is to be a pill pusher, and the LB degree to those too lazy to learn a few manual dexterity tricks and who forget that their last name is DO. At least that way I could tell my coworkers, "Go find a DO" and could at least guess what kind of care they would receive.

Sincerely
James A. Keller Jr.

A Preliminary Study

Outcome Data for Patients Experiencing Chronic Pain

by Edward G. Stiles, DO, FAAO

THE CHALLENGE: Summary articles in the recent medical literature appeared to contradict impressions I have gained in my practice regarding patients experiencing chronic pain.

The first conclusion was that traumatic musculoskeletal injuries, in which the pain persists for two years, should be considered permanent.

The second conclusion was that manipulation is of benefit for only acute injuries, but of little value for chronic pain.

My practice experience did not seem to relate to these conclusions.

THE PLAN: The records for the first 100 consecutive new patients of 1988 were reviewed and the following data was generated. The data from my practice challenges the conclusions of the medical literature.

SEX:	Female	60%
	Male	40%
AGE:	Under 30 years of age	20%
	30 - 60 years of age	57%
	Over 60 years of age	23%
DURATION OF PAIN:	Pain of less than 2 years duration	29%
	Pain lasting 2 - 5 years	19%
	Pain lasting 5 - 10 years	17%
	Pain lasting over 10 years	35%

Therefore, 71% of the patients had pain lasting over two years and should be unresponsive to manipulative care, according to the medical literature.

TRAUMA	Traumatic incident occurre	66%
	Motor vehicle trauma	33%

PREVIOUS CARE:
This indicated the patient had received other care within a few months of entering my practice. Care was provided y neurosurgeons, orthopedic surgeons, neurologist physical therapists, chiropractors, family physicians, emergency room physicians, etc. 73%

Chiropractors/manipulation by others	39%
Osteopathicphysicians/manipulationby others	1%
Dentists	23%

Therefore, these are the patients who have had persistent pain (71% over two years) and are usually categorized as patients with *chronic pain of unknown etiology.*

OUTCOME: The patients were grouped according to their symptomatic improvement.

Minimal (0-30%)	2%
Moderate (30 - 70%)	11%
Marked (70 - 100%)	80%
Unknown (out-of-state)	7%

As the initial fifty charts were reviewed, 48% felt they were 100% improved. Therefore, 71% had pain of over two years duration, 73% of the patients symptoms persisted after previous care, 40% had received manipulation by other clinicians, 66% had a history of a traumatic injury, yet 80% experienced marked improvement. This data challenges the medical literature conclusion that pain lasting for 2 years is irreversible.

OUTCOME
By Duration of Pain:
Patients who attained the marked improvement level:

Pain of 2 - 5 years	76%
Pain of 5 - 10 years	75%
Pain over 10 years	82%

This data suggests that somatic dysfunction was the etiological cause of the pain, will produce symptoms as long as it is present, but that 80% can be helped with specific osteopathic management.

OUTCOME
care time required:
Patients who attained the marked improvement level in:

Less than 4 months of care	66%
4 - 8 months	6%
8 - 12 months	3%
Over one year required	25%

This data challenges the medical literature data suggesting manipulation is effective for only acute pain, but of no value with chronic pain requiring multiple manipulations.

OTHER DATA:	Previous musculoskeletal surgery	5%
	Primary diagnosis of arthritis	4%
	Sponylolisthesis	1%

This data demonstrates that I am seeing the nonsurgical patient. This represents the patients who have continued to experience their symptoms following medical and chiropractic regimes. I believe these clinical conditions persist because their management approaches did not address the somatic dysfunction component

SYMPTOM PROFILE:

Low back pain	51%
Neck pain	48%
Headaches	47%
Upper back pain	46%
Upper extremity pain	40%
Lower extremity pain	21%
TMJ	18%
Lumbar pain	11%
Chest/rib cage pain	10%
Sciatica	9%
Mid-thoracic pain	4%
Lower thoracic pain	2%
Discogenic pain	2%

CHRONIC PAIN PATTERNS — OUTCOME DATA
OUTCOME*

MIN (0 - 30%)
MOD (30 - 70%)
MAX (70 - 100%)

This information is to be used to develop a computer program for collecting future data. It is, therefore, just a preliminary study to evaluate whether osteopathic care might be of value in effectively treating patients with chronic pain. If this data stands further scrutiny, it could lead to a better understanding of the role the osteopathic profession might have in decreasing the cost and increasing the effectiveness of treating patients experiencing chronic pain.

*After the initial visit, the patients are usually seen again in approximately 3 days. If the somatic dysfunction (s/D) is improved, the patient is seen weekly until they have experienced a good week, The patient is then seen bi-weekly until they are doing well for that period. The patients are also frequently asked to rate their symptoms and clinical condition on a scale of 10 - 0 , ie, 10 = original symptom/activity level and 0 being back to normal. Once the two week period is markedly improved(subjectively and on objectively examination), I see the patient in one month. Once the monthly period is good both objectively and subjectively, I re-evaluate the patient in 2 months. If they are doing well, I inform the patient I believe I have completed their course and make a chart notation of PRN. This means both the patient and I agreed we are finished. Thus, both a subjective and objective agreement is reached. 80% of these patients got to this PRN level.

DISCLAIMER: The purpose is not to discredit other forms of therapy or care, but to identify an approach not previously used with these patients.

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5. Ottenbacher K, DiFabio RP: Efficacy of spinal manipulation/ mobilization therapy: A meta-analysis. Spine 1985; 10:833-837.

Edward G. Stiles, D.O. is a former Professor Of Osteopathic Principles and Practices at Oklahoma State University College of Osteopathic Medicine and currently serves as Adjunct Professor of Biomechanics at Michigan State University College of Osteopathic Medicine. Dr. Stiles limits his practice to Osteopathic Manipulative Management in Norman, Oklahoma.

Classifieds

DO Wanted!

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

DO Needed!

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

Books, Skeletons and Skulls Needed

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

Practice for Sale:

Los Gatos, California; cranial - sacral essential, homeopathy helpful; Affluent community; 10 minutes from San Jose, 45 minutes from San Franciso, 20 minutes from Santa Cruz. No HMO, PPO, Medicare or Medicaid. Call Dane J. Shepherd, DO at (312) 782-9153

Opportunity - FP/OMT

Established family practice with OMT opportunity in southern Maine. Contact David DeTurk at the Maine Osteopathic Association for details (207) 623-1101.

Psychiatric Residency Seeks AAO Help in Curriculum Development

Brian T. Fulton, DO, Site Training Director for the UOMHS/Cherokee MHI Psychiatric Residence Training Program, has asked AAO members for assistance in development of osteopathic curriculum for the required course on Psychiatric Principles. He asks for your ideas in expanding the understanding of each of these four concepts as they apply to the practice of psychiatry:

1) Osteopathic manipulative treatment
2) Holism
3) Intrinsic health
4) Attitude within the doctor/patient relationship

You can contact Dr. Fulton or his associate Dr. Erle Fitz at:

Cherokee Mental Health Institute
1200 West Cedar Street
Cherokee, IA 51012
(712) 225-2594

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, IA 50312. The University is an equal opportunity employer.

FOR SALE

French Osteopath Jean-Pierre Barral's Visceral Manipulation VHS Videotape Cassettes Available

WVSOM, OMT Dept. offers a complete set of Dr. Barral's video cassettes on Visceral Manipulation. This is the first Course taught in English and the only video cassettes of his available. Each set contains (4) two-hour cassettes. Cost for complete set is $320 plus $5 shipping and handling.

Contact:
WVSOM, OMT Dept.
400 N. Lee Street,
Lewisburg, WV 24901.

Calendar of Events

MARCH

18-20
Introduction to Visceral Manipulation
Guest Speaker:
Jean-Pierre Barral, DO, MROF
The Broadmoor Hotel
Colorado Springs, CO
Hours: 18 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317)879-1881

21
Intermediate Visceral Manipulation
Guest Speaker:
Jean-Pierre Barral, DO, MROF
The Broadmoor Hotel
Colorado Springs, CO
Hours: 7 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317)879-1881

23-26
Annual Convocation
American Academy of Osteopathy
The Broadmoor Hotel
Colorado Springs, CO
Hours: 29 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

APRIL

23-24
Sutherland's Methods for Treating the Rest of the Body
Bedford, TX
The Cranial Academy & The Dallas Osteopathic Study Group
Contact: Conrad Speece, DO
(214) 321-2673

MAY

18-22
97th Annual Convention
Indiana Association of Osteopathic Physicians and Surgeons
Adams Mark Hotel
Indianapolis, Indiana
Contact: IAOP&S
(800) 942-0501

20-24
30-hour Basic Course
Sutherland Cranial Teaching Foundation
Location: PCOM
Contact: Judy Staser
(817) 735-2498

21-22
Advance Percussion Vibrator Course
American Academy of Osteopathy
AAO Headquarters Building
Indianapolis, IN
Hours: 13 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

JUNE

13
Deadline for applying for November Osteopathic Manipulative Medicine's (OMM) Board examination
Contact: Susan Barnhart
AAO Administrative Assistant
(317) 879-1881

18-22
Basic Course in Osteopathy in the Cranial Field
The Cranial Academy
Oklahoma City Marriott
Hours: 40 Category 1-A anticipated
Contact: Patricia Crampton
The Cranial Academy
Executive Director
(317) 879-9713

23-26
Explorations in Osteopathy
The Cranial Academy
Oklahoma City Marriott
Hours: 20 Category 1-A anticipated
Contact: Patricia Crampton
The Cranial Academy
Executive Director
(317) 879-9713

AUGUST

26-28
Head, Neck and Should Pain; a multi disciplinary approach
Indianapolis, Indiana
Indiana Academy of Osteopathy
Contact: Indiana Association of Osteopathic Physicians & Surgeons
(800) 942-0501

SEPTEMBER

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

OCTOBER

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

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

9-15
National Osteopathic Medicine Week

NOVEMBER

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

University of North Texas Health Science Center at Fort Worth

Texas College of Osteopathic Medicine

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The University of North Texas Health Science Center at Fort Worth invites applications and nominations for a Chairperson of Manipulative Medicine.

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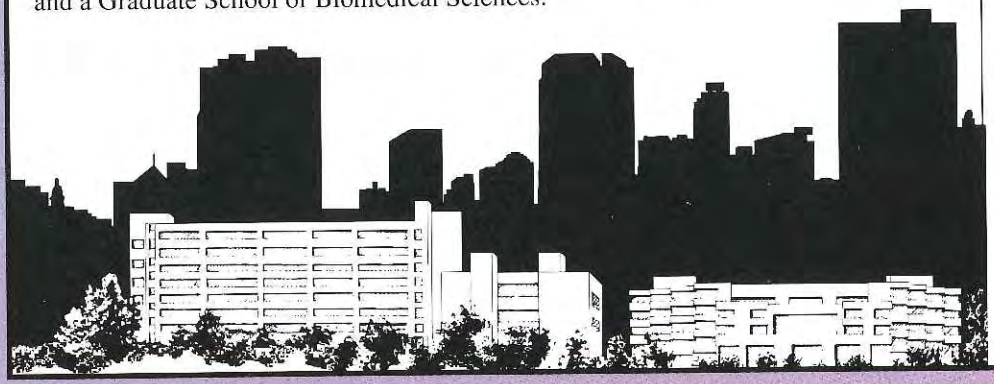

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Send *curriculum vitae*, statement of teaching and administrative experience, and the names of three references by April 15, 1994 to:

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c/o Office of the
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University of North Texas
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