THE AAO
JOURNAL
A Publication of the American Academy of Osteopathy

VOLUME 5 NUMBER 1 SPRING 1995

Challenges and Burdens

...see page 9

New! New! New! New!

American Academy of Osteopathy

Introduces its

Muscle EnergyCourse

April 28-30, 1995

AAO Headquarters Building

Indianapolis, Indiana

Friday, April 28
8:00 am - 5:00 pm

Hour one:
History of and Physiologic Basis for Muscle Energy Technique

Hour two:
Diagnosis of Hip Girdle Dysfunction

Hour three:
Treatment of Hip Girdle Dysfunction

Hour four:
Diagnosis of Innominate Dysfunction

Hour five:
Treatment of Innominate Dysfunction

Hour six:
Diagnosis of Pubic Symphysis Dysfunction

Hour seven:
Treatment of Pubic Symphysis Dysfunction

Hour eight:
Diagnosis of Sacral Dysfunction

Saturday, April 29
8:00 am - 5:00 pm

Hour nine:
Treatment of Sacral Dysfunction

Hour ten:
Diagnosis of Lumbar Dysfunction

Hour eleven:
Treatment of Lumbar Dysfunction

Hour twelve:
Diagnosis of Thoracic Dysfunction

Hour thirteen:
Treatment of Thoracic Dysfunction

Hour fourteen:
Diagnosis of Costal Dysfunction

Hour fifteen:
Treatment of Costal Dysfunction

Hour sixteen:
Diagnosis of Cervical Dysfunction

Sunday, April 30, 1995
8:00 am - 12:00 noon

Hour seventeen:
Treatment of Cervical Dysfunction

Hour eighteen:
Diagnosis and Treatment of Shoulder Girdle Dysfunction

Hour nineteen:
Diagnosis and Treatmenty of TMJ Dysfunction

Hour twenty:
Wrap up: Muscle Energy's Place in the Grand Scheme of Things

Program Chairperson
Walter C. Ehrenfeuchter, DO, FAAO

Faculty
Karen Arscott, DO
John Glover, DO, CSPOMM
John Jones, DO
Evan Nicholas, DO

Course Objective:

A complete twenty-hour course in diagnosis and treatment of somatic dysfunction using muscle energy technique. The physician attending this course will receive instruction in the diagnosis and muscle energy treatments for somatic dysfunction of the hip, pelvis, sacrum, lumbar spine, thoracic spine, costal cage and cervical spine. Common patient presentations will be discussed as well as some of the rarer types of dysfunction.

CME Hours:

2.5 Days - 20 Category 1-A

Fee:

Prior to April 1, 1995:

AAO Member	$475
Intern/Resident	$200
AAO Non-Member	$525

After April 1, 1995:

AAO Member	$575
Intern/Resident	$300
AAO Non-Member	$625

Save $100.00

Register before April 1, 1995

Make Hotel Reservations by calling directly to:

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Indianapolis, Indiana 46204
(317) 635-2000 or 1-800-2-RAMADA

$ 70.00 single/double
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Each Additional Person: $10.00

American Academy of Osteopathy

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

THE AAO
JOURNAL
A Publication of the American Academy of Osteopathy

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

Subscriptions: $25.00 per year

From the Editor

by Raymond J. Hruby, DO, FAAO

Poultry, Pediatrics and Palpation: Who is the Osteopathic Physician?

I am sure that most of you have read and heard much lately about the need for the osteopathic profession to demonstrate its uniqueness. With all the changes in medical practice that may come about because of health care reform, the need for us to demonstrate that we are competent physicians, and that we are parallel to, but distinct from, non-osteopathic practitioners is more critical than ever.

But how can we know who is truly an expert osteopathic physician? How can we know that an osteopathic physician is able to integrate osteopathic principles and philosophy into the full spectrum of patient care? In other words, when is an osteopathic physician really an expert in osteopathic medicine, and how can we measure the extent to which one has accomplished this?

Let me tell you a story that led me to think about this topic. Not long ago, I read an article about someone who went to a livestock fair and saw a chicken that could play tic-tac-toe. Despite taking on some excellent tic-tac-toe players, the chicken never lost a game, and in fact frequently won. This chicken was a very competent tic-tac-toe player.

Now, the simplest concepts of behaviorist theory would explain how a chicken could be trained to accomplish such a feat. But is the chicken a competent tic-tac-toe player in the same way that a DO is a competent osteopathic physician? I would certainly say that the answer is "no". The chicken lacks something the osteopathic physician has. But what is the difference?

Perhaps the chicken does not have an understanding of the concepts of tic-tac-toe. The chicken is not responding based on a careful consideration of all possibilities but rather in an unreflective manner based on the ability to recognize patterns previously presented. But even if we could show that the chicken understood the concepts of tic-tac-toe, this would not prove that the chicken was an expert on the game. The story I read stated that an eight-year-old child would understand the concepts of tic-tac-toe. Yet it is likely that the child would lose to the chicken on a regular basis. That would certainly not be seen as competence on the part of the child.

So the combination of conceptual knowledge and accurate performance does not constitute competence, either in tic-tac-toe or in osteopathic medicine. In other words, we would not say that the combination of the eight-year-old and the chicken is equivalent to being an expert.

The expert must be able to apply conceptual knowledge and accurate performance skills to a wide variety of problem-solving situations. Or, to put it another way, the expert osteopathic physician (or the expert tic-tac-toe player for that matter) must be able to do critical thinking and diagnostic reasoning. Unlike the chicken, the osteopathic physician has the ability to react quickly and appropriately to novel situations.

So we may say that the expert osteopathic physician has the ability to demonstrate flexibility and adaptability in applying osteopathic concepts in the face of new and challenging situations. This is what constitutes expertise and competence in osteopathic medicine. How we can measure this to demonstrate our distinctiveness, I am not sure. What do you think? ❑

A.T. Still Medallion Deadline Nears

The deadline to submit the name of a candidate for the 1996 A.T. Still Medallion of Honor Award is April 15, 1995.

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 additional information about this procedure, please contact the Academy office or refer to page 125 of your 1994 AAO Directory.

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, MSU-COM, Dept. of Biomechanics, A-439 E. Fee Hall, East Lansing, MI 48824

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).

Message from the Executive Director

by Stephen J. Noone, CAE

I continue to be impressed at the level of commitment and the hard work put forth by the Academy's leadership. The period between the beginning of the calendar year and Convocation represents a time of significant activity for over 20 members of the leadership. In my brief experience with the organization, this activity has increased each year.

The Academy has been busy in its efforts to interact with leaders in the American Osteopathic Association to promote the importance of osteopathic principles and practice. AAO President-elect Boyd Buser and liaison Raymond Hruby attended the January meeting of the AOA Council for Federal Health Programs which is shaping the profession's plans for advocating osteopathic medicine with the 104th U.S. Congress and important federal regulatory agencies. Trustee Melicien Tettambel attended the meeting of the AOA Bureau of Professional Education to advocate passage of the Academy's Resolution 200. The 1994 AOA House of Delegates had referred that Resolution to the Bureau for study and a report on implementation of a mechanism to permit allopathic physicians to enroll in osteopathic graduate medical education programs in OMM.

AAO President Eileen DiGiovanna, Dr. Buser and I attended the February midyear meeting of the AOA Board of Trustees where we were able to provide advocacy and counsel on a variety of issues before the Board. There is no question that the respect for the Academy's leadership has grown over the past three years. The leaders of the profession really do care about the Academy's position on important issues.

Academy Trustee Judith O'Connell joined a delegation from AOA to the Health Care Financing Administration (HCFA) in Baltimore. The group met with Terry Kaye, Director of Physician Services, Office of Physician/Ambulatory Care Policy HCFA and Barton C. McCann, MD, HCFA Senior Medical Officer. She played a key role in the group's challenge to HCFA's assignment of work values to CPT codes for myofascial release and joint mobilization, codes requested primarily by allied health care providers. If these values were to remain in effect, there would be considerable disparity between these CPT codes and those assigned for OMT. AAO Past President Herbert Yates, as specialty society representative to the Relative Value Updating Committee (RUC), prepared the AOA's written testimony on this issue. Hopefully, by the time you read this report, the matter will have been resolved favorably.

In addition to this outreach, there has been considerable internal operational activity as well. Chairman Buser convened the Education Committee at AAO headquarters and reaffirmed plans to provide for nine quality continuing medical education programs in osteopathic manipulative medicine this next year.

* September – Introductory Visceral Manipulation
* October – AOA Convention
* October – OMT Update
* November – Basic Percussion Vibrator
* January – Cruise/CME
* February – OMT Update
* March – Convocation
* April – Muscle Energy Course
* May – Advanced Percussion Vibrator

The Committee also is evaluating requests from three AAO members to sponsor NEW CME programs under the auspices of the Academy, illustrating that the Academy is establishing itself as the premier provider of CME in OMM.

The success of the Academy's existing educational programs continues as evidenced by the January Cruise/CME to the Western Caribbean and the February OMT Update, which attracted a record 50 physicians this year. The 1995 Convocation at the fabulous Opryland Hotel in Nashville, Tennessee is expected to reach last year's level of excellence.

The Long Range Planning Committee met under the leadership of AAO Past-President Herbert Yates to review and revise the strategic plan originally adopted by the AAO Board of Governors in 1992. This document continues to provide an excellent blueprint for the organization and its officers, boards and committees. You will learn more about the revisions in this plan at the Annual Membership Meeting on March 22 in Nashville.

If you have the motivation, time and talent to volunteer to join the Academy's leadership in promoting the organization's fulfillment of its long range plan, please communicate your interest directly to President-elect Boyd Buser. He will be completing his recommendations for 1994-1995 committee appointments to the AAO Board of Trustees at their March 20 meeting prior to Convocation. ❑

In Memoriam

Mason B. Barney, DO

Dr. Barney passed away in January after a brief illness.

He was a 1943 graduated of the Kirksville College of Osteopathic Medicine beginning his practice in Manchester Center, Vermont shortly thereafter.

Holding memberships in the North American Academy of Manual Medicine and the Cranial Academy, Dr. Barney was a life member of the American Osteopathic Association and an honorary life member of the American Academy of Osteopathy.

He was a member and past president of the Vermont Association of Osteopathic Physicians and Surgeons, and was involved in the Missouri Association of Osteopathic Physicians and Surgeons, the Maine Association of Osteopathic Physicians and the American College of Osteopathic Family Practitioners. He was an active visiting clinical lecturer to various osteopathic colleges.

Survivors include his daughter, Suzanne of Knoxville, TN, a son, David Barney of St. Mary's, GA and three grandchildren. His wife, Lois (Bitler) Barney preceded him in death.

The Academy sends its condolences to Dr. Barney's family.

John M. Rolles, DO

Dr. Rolles died November 11, 1994, at the age of 87. He had maintained his role as the unofficial leader and coordinator of his graduating class from Des Moines Still College of Osteopathy from which he had graduated in 1952.

Dr. Rolles was raised in Bournemouth, England. Because of very strong links with the local congregational church, he obtained sponsorship to study theology and sociology at Nottingham University. On completion of that training he was ordained as a congregational minister and went to India as a missionary in 1932.

With six weeks of arriving in India, he as engaged to Miss Helen Jean Johnson who was already established in India as a missionary working as the principal of a girl's school. One year later, after his fiancees furlough in England, they were married and continued to work together as missionaries. Throughout those years before and during the second world war, John Rolles was concerned about the physical health of the rural Indian community in which he worked and felt increasingly frustrated at his inability to deal with the sometimes catastrophic health issues. He had always had an interest in manipulative medicine and had considered the possibility of osteopathic training during that time. In 1947, he returned to England with his wife and two children. He tried to obtain conventional medical training in England but was unable to find a place because of his age and because of the preferential placement of ex-servicemen.

Without knowing where his adventure would take him, in 1948, he travelled with his family to the United States and, after short stays in Boston and Chicago, finally obtained a place in the Des Moines Still College of Osteopathy with a preceding premedical year in Iowa Wesleyan College in Mount Pleasant.

His college training in the States was funded from his own work and the work of his wife who took on various teaching lecturing posts as well as jointly the two of them running the local congregational church in Ankeney, Iowa.

On completing his osteopathic training, he returned to India where he set up a rural outreach service, which, at that time, was fairly revolutionary, although it is a model which is now widely practised throughout the Third World.

For a variety of family and personal reasons, John Rolles returned to England in 1956 and took up an osteopathic practise with an American (Dr. Carl Cooke). This collaboration proved fruitful and successful and he had a flourishing practice based in the South of England. During this time his intense drive to teach, train and do research was unfaltering and he became the President of the British School of Osteopathy and took a very active role in the postgraduate training program, which was evolving for osteopaths in England at that time.

After approximately 15 years as a practising osteopath, he retired and, during the last chapter in his life, he continued to have a vigorous interest in medicine, politics, religion and world affairs in general. He was a prolific writer of articles and letters and, in his home, he has left a library of over four thousand books on a very wide range of topics.

His wife, Helen, is living in Southampton, very near to his son, Dr. Chris Rolles, a Paediatrician (and who authors this obituary) and his daughter, Dr. Shirley Firth, who is a lecturer with a special interest in health issues of ethnic minorities.

Dr. Rolles was a member of the Academy and our deepest sympathies goes to his family and friends.

Message from the President

by Eileen DiGiovanna, DO, FAAO

Convocation is rapidly approaching, and my year as president is winding down. It has been a wonderful year with many exciting things going on. Had I not been president, I might not have had the opportunity to meet as many people and go to as many places, as I have been able to do.

The Board of Trustees and the executive director have successfully reduced the budget deficit and moved well along the way to a budget that will be operating in black within the next few years.

The Education Committee has met one of my goals of continued excellence in planning and presenting educational programs. The evaluations for these programs report a high level of participant satisfaction with the programs and the faculty teaching them.

My goal of unity has been a difficult one to achieve but advances have been made. Our working relationship with the AOA has continued to improve in many areas. Members of our Board of Trustees were able to meet with the Board of Directors of the ACOFP and many areas of mutual concerns and needs were identified and plans for shared efforts were made. A Committee of International Affairs was established to determine how best we can work with and assist DOs from other countries. Our proposal for training of MDs and their certification in OMM is still in progress but considerable effort has been invested in getting it completed.

I want to thank the many people who have helped me during this year: Steve Noone and the Academy staff, who have been wonderful to work with and without whom I could never have done my job, Herb Yates and Boyd Buser for their support and assistance, all of the Academy members who have supported and assisted my efforts and, of course, my husband, Joe, for putting up with all my travel and time commitments.

The Academy is indeed an organization you can be proud of, I know I am. With your continued support it will move into the 21st Century as a leading organization of the profession, playing a major role in health care and education.

Challenges and Burdens

by Gary L. Ostrow, DO

Editor's Note: *This lecture was delivered to the American Academy of Osteopathy at the American Osteopathic Association's Convention in San Francisco, California, on November 16, 1994.*

Introduction: *Gary L. Ostrow earned his Doctor of Osteopathy degree from the College of Osteopathic Medicine and Surgery (COMS) in Des Moines, Iowa, in 1977. He completed a rotating internship at Grandview Hospital in Dayton, Ohio, in 1978 followed by a residency in family practice.*

From COMS, Dr. Ostrow received the Rams Head Award for Outstanding Achievement in Manipulative Medicine as well as serving as an OMM fellow. He is board certified by the American Osteopathic Board of Family Physicians.

Dr. Ostrow holds membership in the American Academy of Osteopathy; American Osteopathic Association; Cranial Academy; International Academy of Applied Nutrition; American Association for the Advancement of Science and the New York Academy of Osteopathy.

He has served on the AAO Board of Governors; AAO Board of Trustees; Cranial Academy Board of Directors and the New York College of Osteopathic Medicine's Board of Governors as well as various committees in each organization. He has lectured all over the United States as well as in China at the Chinese/American Teaching Tutorial International Conference.

In his work as a physician and teacher, he has remained true to the osteopathic concept upon whch the profession and the Academy was founded. In recognition of his loyalty and of his many contributions to the osteopathic profession and the American Academy of Osteopathy, the Academy deems it an honor to present the twenty-first Thomas L. Northup Lecturer Award to Gary L. Ostrow, DO.

Dr. Ostrow: I am deeply honored by this award and wish to thank the Academy membership and the Board of Trustees for this honor. I have not arrived at this point in my life without the great support of my parents, the patience of my wife and daughter, the inspiration of my teachers, almost all of whom have been Academy members, and without the help of my patients and my staff. I would like to give special thanks to the memory of J. Gordon Zink, DO, FAAO, for his inspiring and exciting approach to osteopathy. As many of you know, Thomas L. Northup was one of the founders of the American Academy of Osteopathy. It was through his persistence and leadership that the Academy got its start in 1937. He was the original secretary-treasurer of the Academy which at that time was known as the Osteopathic Manipulative Therapeutic and Clinical Research Association. One of the happier occurrences of having to prepare this speech is that I had good reason to read the American Academy of Osteopathy's Northup book and to review Thomas Northup's contributions to the literature. He was truly the complete osteopathic physician, having written on such subjects as the management of foot disorders, sacroiliac problems, connective tissue disorders, hypertension, cranial treatments, osteopathic reflex diagnosis and structural diagnosis. His service to the profession remains as a role model to all of us.

As in all organizations, the goals of the Academy cycle and recycle. As R. McFarlane Tilley pointed out in a previous Northup lecture, the stated goals of the Academy have evolved, changed, and are currently recycling back to its original 1937 goal statement i.e.: "That the foremost objective and purpose of this association is to develop the science and art of Osteopathy to the fullest possibilities its principles justify." We can contrast this to the 1943 goals that Tilley noted, which were, "To develop the science and art of Osteopathic manipulative therapy." A current review of the Academy's long range goals clearly indicates a trend toward the more expansive goals of our original founders, goals that go beyond the teaching of techniques.

As Norman Gevitz pointed out in his seminal paper entitled *Parallel and Distinctive: The philosophic pathway for reform in osteopathic medical education,* "The osteopathic profession must justify its existence because of its belief that the musculoskeletal system plays a greater role with respect to

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health and disease than is conventionally recognized and that palpatory diagnosis of the spine and manipulative treatment are important aids to overall patient evaluation and management." This must be the central premise, as Gevitz points out, for the basis of our maintenance of our undergraduate and graduate educational programs. Any other tinkering with the program would be beside the point. I concur with this premise. Undoubtedly Thomas Northup would have agreed also.

I believe it is self-evident that the Academy has lived up to its responsibility in promoting osteopathic distinctiveness. Why, then, do we have to recycle our goals?

I would like to relate to you a story that some of you may be familiar with the story of the Buddhist monk and the Christian missionary. There once was a Buddhist monk who became interested in the Judeo-Christian religions. He travelled to America and eventually became a Christian missionary. He travelled back to India where he found one of his former fellow Buddhist monks. They decided to make a religious pilgrimage back to their old monastery which was on the top of a very high mountain. It was a very cold winter's day as they started up the mountain.

Half way up the mountain, as it was beginning to get darker and colder, they heard a faint, distant cry coming from a ravine. They looked down and saw a man lying on the ground obviously in great pain from a fall. He was near death. The Buddhist and the Christian then engaged in a philosophical discourse as to what they should do — the Buddhist being of the opinion that it was obviously God's will and the man's karma that he die a terrible death. The Christian, on the other hand, believed that God had put him at this point on the mountain to help his fellow man.

After several minutes of discourse they decided to part amicably with the monk continuing up the mountain alone and the missionary venturing down into the ravine to see if he could help his fellow man. When he reached him, he saw that this fellow had several fractures of his legs and his pelvis and could not possibly walk. He had to hold him with a blanket that the injured man had with him. So, the Christian put the man on his back and wrapped the blanket around both of them to hold him on his back, and carried him up the ravine very slowly.

And, so it is with the organization of the Academy that once we achieve our goals, meet our challenges, carry our burdens, it is time to move on to new ones. We need new burdens, new challenges to keep us alive. Sometimes we need to recycle old ones.

It was getting much colder as they continued up the mountain, and the temperatures were becoming sub-zero. The missionary began to wonder if either of the two men would make it before the elements killed them both. But just as he began to have those thoughts, he noticed in the distance the lights of the monastery. At that point he knew that he would be able to make it there. However, suddenly he tripped over something in the road. He discovered that he had fallen over the frozen body of the Buddhist monk.

Now there are many ways to interpret the moral of this story, but the one that I favor is that man's greatest burden is to have no burden at all. The missionary with his burden wrapped around him stayed warm enough to survive, while the monk who chose to have no burden died.

And, so it is with the organization of the Academy that once we achieve our goals, meet our challenges, carry our burdens, it is time to move on to new ones. We need new burdens, new challenges to keep us alive. Sometimes we need to recycle old ones.

It was 20 years ago when I first went to an Academy meeting. It was the convocation in Colorado Springs at the Broadmoor Hotel. I was a second-year student at the College of Osteopathic Medicine and Surgery in Des Moines, Iowa. I will never forget the friendship that several Academy members showed me, and I will never forget the inspiration that I got from listening to the anatomical lectures of Dr. Paul Kimberly, the lecture on the stress of gravity by Dr. Little, and the wonderful table sessions led by Dr. Harold Magoun, Jr. and Dr. Edgar Miller. At that point in my career as a second-year student at an osteopathic medical school where osteopathic principles and practice were rarely taught and never integrated, the Academy provided me with a spiritual and academic home. But as I looked around that convocation, I was shocked to realize that I and the other student who I had driven out to Colorado with were the only two students in the entire convocation. The following year at Portland, Oregon, I gave my first public address to the Academy which was a ten-minute presentation on the status and needs of the undergraduate academies. I urged — no, I pleaded with — the Academy to open its meetings to students. My perspective was that the greatest challenge to the Academy was to open its doors to the undergraduate students. The Academy has met that challenge and exceeded my wildest dreams in getting student involvement. Now there is a National Undergraduate Academy of Osteopa-

thy, and over 200 students come to the convocation yearly.

In the late 1970's and early 1980's, it became apparent to me that the teaching of osteopathic principles and practice and manipulative techniques were extraordinarily fragmented and limited at our medical schools. The Academy responded to this challenge by developing a muscle energy tutorial program of which I was one of the early members. Over a period of several years, we were tremendously successful in getting some standard nomenclature and standardized techniques into the medical colleges. I believe that the great, long term significance of those tutorials was the tremendous influence that has continued to be felt through the colleges and the departments of osteopathic principles and practice. I believe that this tutorial approach serves as a paradigm for how we can make, over time, future inroads into the college curriculum.

Later, as I matured into my roles at the Academy, in my teaching at the New York College of Osteopathic Medicine and in my teaching around the country and abroad, it became apparent that the Academy needed to focus on presenting research relevant to osteopathic principles. Therefore, I was thrilled to become a member of the Golden Ram Society and to help sponsor the international research conferences over the past eight years. Thus, while we continued to excel at the teaching of techniques, we simultaneously pursued the active dissemination of research.

Most recently, one of the trends within the Academy has been the reinvigoration of our interest in the treatment of visceral diseases through the application of osteopathic principles. This has been most clearly shown through our recent convocations as well as through the efforts of several academy members at the college level. This is also clearly evidenced by the Academy support of full-time osteopathic clinicians in the hospital setting as well as our support of residencies in osteopathic manipulative medicine in our hospitals.

challenges that have been met by the Academy. . . the challenge of the integration of students in the Academy affairs and presentations; the challenge of trying to improve the uniformity of our diagnostic and treatment terminology effected by the tutorials and their subsequent effect on college curriculums; the challenge of research which was met by the introduction of international research symposia and the reinvigoration of our interest in visceral treatment to help maintain our distinctiveness.

Thus, in the 20 years I have been in the Academy, four significant challenges have been met. Many others were met, but time does not permit me to go into detail. In summary, they are the challenge of the integration of students in the Academy affairs and presentations; the challenge of trying to improve the uniformity of our diagnostic and treatment terminology effected by the tutorials and their subsequent effect on college curriculums; the challenge of research which was met by the introduction of international research symposia and the reinvigoration of our interest in visceral treatment to help maintain our distinctiveness. I am sure that Thomas Northup would have been extremely proud of the Academy's tremendous accomplish-ment over the past 20 years.

For the next 20 years, the Academy has set out some long term goals that I would like to discuss and give my perspective on. The Board of Governors of the Academy established in 1993 and 1994 as its second most important goal that the Academy would become the pre-eminent, worldwide source of education on Osteopathy by the year 2000. This is a noble goal, and I think we need to look at who and what our competition is for that preeminent place and what we can do to achieve this goal. A review of the recent literature from around the country indicates that there are many journals devoted to aspects of manual medicine. These include the *Journal of Manipulative and Physiological Therapeutics*, which has both peer review scientific research as well as case studies on areas of keen interest to our profession. This journal is primarily a chiropractic journal. Then there is the *Journal of Myofascial Therapy* which includes formal papers on research as well as many papers on clinical techniques and clinical protocol. This is primarily published by physical therapists, chiropractors and some MDs as well as PhDs. The Journal of Orthopedics and Sports Therapy also has increasingly been publishing articles on manipulative medicine, such as the "Effects of myofascial release leg pull and isometric contract relax techniques, on straight leg raising" in September 1994[4],and before this in August 1990[5] they had an article on "Clinical testing for cranial vertebral hypermobility syndrome," as well as

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various other articles on manual medicine over the past four or five years. The *Journal of Physical Therapy* has in the past two months published an article on inter-rater reliability of craniosacral rate measurements.[6] *The PT Magazine* recently published an article on what I thought was a uniquely osteopathic concept entitled *Peeling The Layers Of The Onion: Myofascial Release*, published in September of 1994.[7] There are also excellent American journals produced primarily by MDs and DOs who practice orthopedic medicine.

There are also international journals that come out of Europe that are devoted to what have traditionally been considered osteopathically oriented ideas. Textbooks on medical manipulation are coming from Australia, New Zealand, Great Britain and Canada, in English as well as French, German and Danish publications.

We must also take notice of the fact that the allopathic profession is showing greater interest in relevant osteopathic topics. The *American Journal Of Family Practice* recently had an article on the "Ten step musculoskeletal screening protocol" that has been a part of our profession for the past 20 years. The Orthopedic Residency Program at the University of Rochester School of Medicine teaches the residents manipulation from the Cyriax approach.

The Medical College of Ohio at Toledo recently received funding from the government to assess the effects of massage therapy on HIV positive patients measuring changes in CD4 and natural killer cell levels.

At the University of Miami School of Medicine, there is a whole institute devoted to research into therapeutic touch. Its researchers have authored several articles over the past few years, and they have funding for several additional studies. Increasingly MDs are becoming interested in manual medical techniques, both in the primary clinical setting as well as for research potential. The later has been accelerated by the development of the National Institute of Health Office Of Alternative Medicine.

Furthermore, one has only to spend a few minutes perusing some of the physical therapy journals to see the tremendous number of courses that are offered in manipulative techniques. This perusal also reveals that some of our teaching institutions and some former and present Academy members are involved in the dissemination of manipulative skills to MDs and non-physicians.

What saddens and what angers me is the infrequent reference in these articles to osteopathic manipulation, or to our great teachers who developed these diagnostic and therapeutic approaches. But, since these are not historical articles, one can argue that it is inappropriate to mention the profession or degree of the discoverers and teachers of these approaches.

So, it is no surprise that non-osteopathic health care professionals believe that myofascial release was discovered by a physical therapist; or that craniosacral work was developed in the 1970's and not by William Garner Sutherland; or that joint manipulation is rooted either in British orthopedic history or American chiropractic practice.

Since there are 20 to 30 times as many MDs as DOs in this country, twice as many physical therapists, and one and a half to two times as many chiropractors, it is inevitable that the actual practice and teaching of manipulative therapeutics can never be the preeminent role of the Academy for people outside the profession.

The Academy will always remain pre-eminent within the profession in terms of the teaching of techniques. But it is unrealistic for us to continue to presuppose that ten years from now we will still be the leaders in teaching people outside of our own profession.

However, there are areas where we can and will maintain or achieve pre-eminence both within and without our profession. Allow me to elaborate.

To see in which direction the Academy needs to go to remain pre-eminent over all these other individuals, groups and organizations, I would like to try a little experiment. I would like all the practicing DOs to please stand. Now I would like you to remain standing if you feel comfortable with diagnosis and treatment using your osteopathic skills to treat a patient who has shoulder problems, neck problems or low back problems. Please remain standing. Okay, now I would like you to remain standing if you would feel comfortable in developing and executing a research project utilizing standard scientific protocols to evaluate manipulative medicine, procedures and skills. I think it is evident from this experiment that almost all Academy members are skilled in manipulative medicine for diagnosis and treatment utilizing osteopathic principles. However, even among the elite, there are many who feel unskilled in putting forth a research protocol on those very same diagnostic and therapeutic skills.

Therefore if the Academy is to truly attain pre-eminence by the year 2000, we will need to have greater emphasize on research. My first recommendation is based upon my experience with the muscle energy tutorials: that the Academy develop a two-and-a-half to three-day tutorial program to teach practicing clinicians as well as academicians the skills and knowledge necessary to do relevant osteopathic research. I believe that if this is conducted over the next four to six years, that we will infiltrate and influence the osteopathic medical schools and hospital programs just as the muscle energy tutorials did through the late seventies and eighties.

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AAO Case Study: Chronic Upper Extremity Pain

by Guy DeFeo, DO

Persistent upper extremity pain following multiple surgical decompressions of compromised distal neural structures suggests that alternative etiologies exist which are producing the persistent pain and decreased physiologic function of the upper extremities. This case will demonstrate the importance of the identification of abnormalities within the axial skeleton that can have affect on the functional relationships of the upper extremities.

Report of Case

Patient BJ is a 46-year-old white female referred for osteopathic evaluation and treatment by a massage therapist, who had been working with the patient for several years for treatment of multiple somatic complaints. The patient's chief complaint is that of daily headaches as well as severe pain throughout the upper thoracic region and the inability to do most simple tasks with her upper extremities without causing severe pain. Patient's history reveals development of numerous upper extremity complaints at the elbow and wrist while working in a shoe factory. She had several surgeries including carpal tunnel release of the right wrist and radial tunnel release of both elbows approximately six-seven years prior. Since that time, she had had numerous medical evaluations including neurological, orthopedic and radiographic examination of the upper back and neck. X-rays of the cervical and thoracic spine revealed no structural abnormalities. EMG testing revealed no residual neurological deficits in the distal upper extremities. The patient states that the only significant therapy which has reduced her symptoms has been that of massage therapy, which over the past two years, had been performed on a twice weekly basis.

At the time of initial consultation, the patient complained of extensive mid-thoracic pain that had recently become more acute and radiating into her neck causing severe tension type headaches over the past several months. These symptoms had gradually increased over the past one-and-a-half years and been nonresponsive to other therapies.

The patient was able to take nonsteroidal anti-inflammatory medication at low dose for approximately two weeks but then would experience adverse symptoms. There was no other significant medical or surgical history, and the patient had been unable to work for seven years and found it difficult to perform simple activities as a volunteer in a nursery school.

Physical examination revealed a pleasant 45-year old white female who appeared somewhat uncomfortable during the initial examination. Postural evaluation revealed increased thoracic kyphotic curve with the apex at T5-6, which was markedly tender to palpation bilaterally. Paravertebral muscle spasm was noted throughout the entire upper thoracic region and into the paracervical regions. Cervical range of motion was markedly reduced in all planes with subjective complaint of pain with active motion. Passive range of motion was approximately 35° bilaterally in rotation and 10° bilaterally in sidebending with flexion restricted to approximately 60°. Involuntary guarding was noted throughout the passive exam. Examination in the supine position was restricted since the patient found it difficult to remain in this position for a period of time. There was tenderness noted in the upper cervical region with C2 rotated right, motion restriction noted in the occipitoatlantal joint with tenderness to palpation bilaterally. C6-7 were rotated left with the thoracic inlet rotated and sidebent to the right. Craniosacral evaluation revealed a left sphenobasilar torsion as well as compression of the frontal bone with restriction noted at the left frontosphenoid suture. The patient was returned to a seated position secondary to complaint of pain.

Further examination of the upper extremities revealed surgical scars over the dorsal aspect of the right elbow and the volar aspect of the right wrist, as well as the dorsal aspect of the left elbow. The patient could not tolerate testing of deep tendon reflexes in the upper extremities. Sensation to light touch and pinprick was diminished throughout the upper extremities from the elbow distally and bilaterally. Grip strength was reduced significantly in the right hand.

Evaluation of the lower extremities revealed no abnormal findings and gait

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Letter to A. T. Still

by Raymond J. Hruby, DO, FAAO

Dear Doctor Still,

Of the principles of osteopathic medicine you left for us, I think the most important one is the concept of the interrelationship between structure and function. You yourself indicated that the principles of body unity (or holism) and self-regulation were not new ideas, you simply revived their usage in medical practice and incorporated them into your treatment approach.

The principle of interrelationship of structure and function, however, is unique. You recognized the importance of the musculoskeletal system in health and disease and provided a method for dealing with this important system. You were the first to incorporate this important idea into the total care of the patient.

One of your students, Wilfred L. Riggs, DO,(who later became a faculty member at the American School of Osteopathy), wrote a book entitled *Theory of Osteopathy*. In it, on page 11, he points out the importance of the structure/function interrelationship. He says: "The science of Osteopathy has magnified the importance of the spine as a guide in diagnosis, basing such diagnosis upon the well-known physiological law of transferred sensation and the anatomical connection between spine and viscus. From this fact comes our accuracy in diagnosis, an accuracy which is based on mathematical calculation and cannot fail. The variations which occur in the relations and structure of different parts of the organism sometimes produce embarrassing results to the surgeon and fatal ones to the patient. These variations are rarely sufficient to embarrass the osteopath, though he must ever be ready to correct errors in diagnosis due to variations in position of lesion by examination of the viscus affected."

As we practice our skills from day to day, we should remember the importance of this relationship between structure and function. We should also remember how significant it is that you discovered this important principle.

Your ongoing student
Raymond J. Hruby, DO, FAAO

Asthma Treated by Visceral Manipulation

by Daniel Bensky, DO
Seattle Institute of Oriental Medicine

Editor's Note: *Daniel Bensky, DO earned his DO degree from the Michigan State University College of Osteopathic Medicine in 1982. He holds membership in the American Academy of Osteopathy, American Osteopathic Association, Acupuncture Association of Wasington and Oriental Medicine Publishers Group. Dr. Bensky is presently in private practice in Seattle, Washington, and is medical editor of the Eastland Press.*

Asthma is a serious condition that is becoming more and more prevalent in our society. It has increasingly been the object of a wide variety of medical treatments.[0] There so are many precipitating causes that the search for any particular patient's reason for having asthma should not be limited to the respiratory system. Similarly, pharmacological manipulation is not always the treatment of choice. With a wide enough perspective on manipulation, it is possible to find the cause of some patient's asthma and treat it effectively at a relatively low cost.

Report of a case

A 49 year-old caucasian woman came to our clinic with acute back pain. This pain had first occurred approximately two years previously and had gotten progressively worse over the last year. It was located primarily in the lower lumbar and sacral area but occasionally also in the thoracolumbar junction. It was exacerbated by intense physical work. She had been recently doing a lot of gardening and had developed acute pain the day before the visit. When she either bent or reached forward, she felt as if she had been kicked in the lower back.

Asthma is a serious condition that is becoming more and more prevalent in our society.

This woman also had a long history of sensitivity to smoke and began to have attacks of wheezing approximately two years prior to this visit. These attacks had become more severe over time. Now now she usually felt very constricted in her upper chest ("no room to breath") and often had trouble breathing (especially inhaling). She was able to sleep only four hours a night due to difficulties in breathing when she laid down or even just reclined. Although she did have a history of allergies (primarily sinus), she had no prior history of asthma. Skin tests done approximately a year before her visit showed severe sensitivity to cat, rabbit and grass. She was positive to house dust, mites, dog, feathers, mold and birch pollen among other substances. She had been diagnosed by a pulmonologist as having steroid-dependent extrinsic asthma.

Other history included gastroesophageal strictures dilated two years prior to the visit. She had a hysterectomy 12 years previously and a bunionectomy on the right four years previously.

At this time it was decided to focus treatment on her back pain and to return to the asthma when the back was no longer acute. During the next month, she was seen six times for osteopathic manipulative treatment. Treatments were primarily myofascial release to the sacrum and cranium along with the respiratory and pelvic diaphragms. At this time her back pain was greatly improved and she had returned to all normal activities.

Over the next month the patient had three treatments with osteopathic manipulation to treat her asthma. Techniques such as muscle energy, counterstrain and myofascial release were applied to the cerivicothoracic junction and related tissues. No positive effect could be noted.

During this time she was taking the following medications: Azmacort (2 puffs qid), Brethaire (2 puffs tid), and Tagamet (300mg q hs). The results of a recent spriogram were FVC at 2.68 L (73% of predicted), FEV_1 1.94 L (69% of predicted).

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At this time it was decided to reevaluate the patient from a structural standpoint. The primary palpatory techiniques used were general and local listening.[1] These are done by placing one's more sensitive hand on the body and feeling for very slight pulls from the connective tissue. When this is done systematically it can lead to the identification of a small number of key restrictions. On examination of this patient, it was decided that her most important structural restriction was the gastroesophageal junction. Manipulation of this area[2] became the focus of treatment with attention also being paid to the left apex of the pleura and the T_4/R_4 area on the left. Even though the patient suffered some trauma (slipping and falling down the stairs) soon after this, she immediately began sleeping better and was soon breathing more easily in general. She slowly began tapering off her medications. Less than four months (and five treatments) later she was completely off all medications, breathing well and very active physically. Two months later the patient was persuaded to have another spirometry. At this time her FVC and FEV_1 were both over 94% of predicted.

We have followed her progress over the last five and one-half years. Rarely has she felt a tightness in her chest with severe colds but has never had any noticeable wheezing nor has she used asthma-related medicines of any kind. She has become an avid golfer. While she continues to have occasional mild lower back pain, it is always precipitated by intense physical activity and rarely lasts more than one day.

Discussion

This case brings up two major issues. The first is the relation of gastroesophageal dysfunction to asthma. The second is the place of the viscera in the conceptual framework of osteopathic manipulative therapy.

There is much evidence that gastroesophageal reflux (GER) is an important cause of chronic respiratory disease, especially asthma.[3] Some authors believe that asthmatics whose disease requires systemic steroids or are otherwise uncontrolled should be suspected of having GER. It can be taken as far as saying that there is a "yin-yang" relationship between GER and asthma.[4] There have been studies of both medical (usually H_2-blockers) and surgical (such as modified posterior gastropexy) interventions in the treatment of GER related asthma.[5] Some studies using H2-blockers have been disappointing or only given modest improvement of nocturnal asthma symptoms.[6] Note that in this case the nocturnal problems were the most acute and were among the first problems to improve.

This case brings up two major issues. The first is the relation of gastroesophageal dysfunction to asthma. The second is the place of the viscera in the conceptual framework of osteopathic manipulative therapy.

The second issue involves what exactly is osteopathic manipulative treatment (OMT)? At various times and in various authors' minds, OMT has either been limited to joint manipulation or includes various soft tissue treatments. It is clear that to the vast majority of osteopathic physicians OMT is the manipulation of musculoskeletal structures. Even in the schools of technique that utilize the fascia, such structures as the peritoneum or pleura are either ignored or treated in a vague manner. When a "structural exam" is performed as part of the physical exam, the viscera (with the possible exception of the brain) are studiously ignored. This is not a new attitude. For example, an article written over 50 years ago entitled "The stomach osteopathically considered" contains not a single reference to the anatomical structure of the stomach or any of its attachments. It concentrated solely on the spinal and nervous relations of this organ.[7]

Why have the viscera been excluded from the osteopathic gaze? There are many studies on smooth muscle that support the view that it can be effected by manual means. For example it is known that vascular smooth muscle responds to stretch with an increase in active force development.[8] Studies on the reaction of the smooth muscle of the bladder[9] and intestines[10] to pressure also show smooth muscle physiologically contracts when stimulated. The studies also explain some of the mechanisms for this contraction. Manual intervention has been shown to have an effect on the viscera. For example, one study showed that an increase in intra-abdominal pressure leads to an active contraction of the gastroesophageal junction (probably from contraction of the crura).[11] Is it not reasonable to expect the connective tissue of the viscera (pleura, peritoneum, etc.) to react to manual treatment just as other forms of connective tissue do?

One of the main contributions of osteopathy to the healing arts is the linking of structure to motion and to health. As such, OMT should include

any manual treatments that improve the motion of any bodily structure that has an impact of health. Within this paradigm the type of osteopathic manipulation practiced by the vast majority of osteopathic physician today is an 'eviscerated osteopathy'. Our science and healing art require constant change and growth to remain viable. I would argue that inclusion of the viscera is another important expansion of the osteopathic concept.

Summary

This case involves a woman with asthma, most probably related to gastroesophageal reflux. While being on medical therapy she was treated with OMT on the musculoskeletal system with no results. When the focus of treatment was changed to the viscera, she responded well and has continued to do well for over four years. This case supports the idea that when a condition such as asthma is diagnosed, it is vitally important that the cause of the problem is clearly understood. It is also important for us to expand the osteopathic concept of structural mobility to include the viscera.

[0] D'Alonzo, G.E., andKrachman, S.L., 1993. "Diagnosis and management of asthma: A brief review of two asthma expert panel reports" *Journal of the American Osteopathic Asssociation* 93(6) 679-700.

[1] For a more extensive discussion of this diagnostic technique see Barral, Jean-Pierre, *Visceral Manipulation II.* (Seattle: Eastland Press, 1989), 8-13.

[2] *ibid.*, 63-4.

[3] Howard, P.J., and Heading, R.C., 1992 "Epidemiology of Gastro-Esophageal Reflux Disease" *World Journal of Surgery* 16 (2)288-93.

[4] Mansfield, L.E., 1989. "Gastroesophageal reflux and diseases of the respiratory tract: a review" *Journal of Asthma* 26(5),271-8.

[5] Larrain, A., Carrasco, E., Galleguilos, F., Sepulveda, R., Pope II, C.E., 1991. "Medical and Surgical Treatment of Nonallergic Asthma Associated with Gastroesophageal Reflux" *Chest* 99 (6), 1330-5.

[6] Sontag, S.J., 1991 "Gut Feelings about Asthma" *Chest* 99 (6), 1321-4. This editorial is an excellent overview of this subject.

[7] Pearson, W. M., 1940. "The Stomach Osteopathically Considered" *The Journal of Osteopathy* 47 (3), 21-3.

[8] Davis, M. J., Meininger, G.A., Zawieja, D.C., 1992 "Stretch-induced increases in intracellular calcium of isolated vascular smooth muscle cells" *American Journal of Physiology* 263 (4 pt.2) 292-9.

[9] Glarum, J.J., van Mastrigt, R., Romijin, J.C., Griffiths, D.J., 1987 "Isolation and individual electrical stimulation of single smooth-muscle cells from the urinary bladder of the pig" *Journal of Muscle Research and Cellular Motility* 8 (2), 125-34.

[10] Kirber, M.T., Walsh, J.V., Jr., Singer, J.J., 1988 "Stretch-activated ion channels in smooth muscle: a mechanism for the initiation of stretch-induced contraction" *Pflugers Archives* 412 (4), 339-45.

[11] Mittal, R.K., Fisher, M., McCallum, R.W., Rochester, D.F., Dent, J., Sluss, J., 1990 "Human lower esophageal sphincter pressure response to increased intra-abdominal pressure" *American Journal of Physilology* 258 (4 pt.1) 624-30.❑

Letters To The Editor

Dear Editor;

I have read with great interest the editorial, titled "The Uniqueness of Osteopathic Medicine: Do We Know What it is?" in the Winter 1994 issue of the Journal. In the concluding paragraph, readers were invited to send in our ". . .ideas about what makes osteopathic medicine different." I accept this invitation.

As is reflected in my "prolific" (your word) writings, I have long felt that the profession's emphasis on its "distinctiveness" and "uniqueness" as justification for its "...existence as a separate profession in the world of medicine" is unfortunate. I find no value in being different just for the sake of being different. What matters is what is accomplished with the difference.

To paraphrase statements made in my 1990 article that you cite[1], the unanswered question that continues to confront the osteopathic medical profession is: "What enhancements of human health and welfare do your alleged distinctions enable you to contribute, and what persistent and prevalent health-related problems can you solve that cannot be accomplished by any other profession in the world of medicine"? That is the awaited and ultimate distinction!

In that same article (and others), I sought to demonstrate that the profession is being presented with historic opportunity to meet increasingly urgent health needs, brought by ongoing demographic and other changes in our society, for which the profession is uniquely prepared by the philosophy — the strategy— that avowedly guides osteopathic practice. That guiding philosophy is precisely what is required at this stage of our epidemiological history — well into the next century, Those needs are not being met by the prevailing strategies despite the impressive and even valuable advances in technology and by the endless succession of "breakthroughs".

What is that osteopathic philosophy? Let me paraphrase again:

One: The recognition of the following:

a) the unity of body and person; that each part's functional quality affects and is affected by the competence of all other body parts;

b) that the com petence of the body parts is influenced by the entire history of the person, beginning with conception, and by the unique and continually changing constellations of circumstances, factors and influences in each individual's life;

c) and, therefore, that true health care must be of the person by modification of such major factors as are subject to modification, in directions that favor the recovery and enhancement of health. This is to be distinguished from disease care largely or solely directed at the bodily components and processes that have been victimized by those factors and circumstances, important as that may be. "To find health should be the object of the doctor." Anyone can find disease. (A. T. Still)

Two: a) Recognition of, and total dependence on each person's indwelling "health care system; that it is not only a system" that defends and heals but is a real "health maintenance organization."

b) Awareness that, given a favorable balance of health-affecting factors in each person's life, it is the ultimate source of health and of the recovery of health; that health and healing come from within. Health cannot be transfused like blood or transplanted like a kidney.

c) Acknowledgment, therefore, that the highest function of the physician is to give support to the competence of each patient's indwelling healthcare system, to remove impediments to its function and to teach patients to do the same for themselves.

d) Among the most common impediments are the musculoskeletal dysfunctions that are the traditional focus of osteopathic practice. Unlike most other impediments and deleterious factors (such as habits, customs, environments, behaviors, economic status, diets, abuse of body and mind, etc.) somatic dysfunctions readily subject to favorable modification by appropriate skills.

Three: Recognition of the following about the human musculoskeletal system:

a) It is the most massive system in the body, placing the greatest demand upon other systems for energy and maintenance.

b) It is the ultimate instrument of human behavior, through which one acts out ones' humanity and individuality and is profoundly affected by the overall quality of each person's total behavior.

c) The human musculoskeletal system is, because of its upright conformation, uniquely vulnerable to gravitational and other external forces.

d) Being richly innervated and vascularized, the musculoskeletal system is in continuous and intimate communication with all other parts of the body. Its impairments and dysfunctions inexorably affect other cells, tissues and organs and their impairments are reflected in components of the musculoskeletal system.

Four: Research has richly documented that such musculoskeletal dysfunctions exaggerate the impact of other detrimental, and often less modifiable, factors in the person's life. Through neural connections their collective impact is directed to other tissues and organs, including components of the homeostatic, defensive, health-maintaining and health-restoring systems.

The longer the musculoskeletal dysfunction exists, the greater the toll taken on the competence of the affected body parts and, therefore, on the individual's health. Osteopathic manipulative treatment, therefore, has enormous health-enhancing and preventive as well as therapeutic value.

For these reasons, osteopathic manual medicine is a central and strategic component in the implementation of the osteopathic philosophy discussed above. It is of special and unique value at this stage of our demographic and epidemiological history, in which, as the proportion of aged in the population continues to increase, so has (and will) the predominance of the chronic, largely incurable, irreversible degenerative diseases which require costly, long-term "high-tech" care.

It is becoming increasingly evident that these afflictions are not inherent aspects of the aging process. (Aging itself is not a pathological process!) They are the products of the progressively larger tolls taken even by seemingly inconsequential factors, circumstances and impediments the longer one lives. In short, these diseases are largely preventable. Widespread implementation of the whole-person approach that characterizes the osteopathic philosophy is the required strategy. Unfortunately, the osteopathic medical profession is so deeply absorbed in being mainstream, that it seems to have forgotten that it came into existence to lead the way upstream — to fundamental medical reform. It is not yet too late to return to the mission. But it will require that the profession's resources and its educational system be aimed at the dominant health needs of the nation. It short, it may require that the profession become a focused profession, rather than a diffusely "complete" one.

[1]Korr, I. M. Osteopathic medicine: the profession's role in society. JAOA, Vol. 90, No. 9, Sept. 1990.

Irvin M. Korr, PhD
Boulder, CO

Dear Editor:

The AAO Journal published Dr. J.M. McPartland's letter to the editor in the volume 4, number 4 winter issue on page 7. Since no editorial comment followed, I will reply.

The author of the letter made comments which were quite complimentary and very much appreciated. Furthermore, I welcome his future endeavor to add to our understanding by encouraging careful work.

With regard to debate, I wrote that signifcant side effects associated with the drug approach occur . . . . "on a scale which absolutely pales into comparison with any conceivable side effects reported to date associated with the widespread use of Sutherland's techniques."

This clearly is not the same as writing that one of Dr. Lipton's suppositions (is) "that widespread use of Sutherland's techniques has not caused any conceivable side effects."

As a practitioner, I share Dr. McPartland's concerns particularly with regard to heart palpitations. I have also been aware of drops in heart rate below 40 bpm and seizure activity as well to mention but a few side effects. These occurred in individuals prone to this activity. Similarly, as a physiatrist, I share the concern for using skilled and appropriate technique in treating traumatic brain injury as significant side effects can occur in these patients. I look forward to his reporting on side effects along with Dr. Greenman so that I may learn, once again, from my colleagues, more about our work. As an author, I stand by my work as written and can be reached for further comments at (804) 398-7266. I almost missed the letter and do not want to create the impression Dr. McPartland's concerns should go unaddressed. I think he raises an important point.

Very respectfully,
Jamie Lipton, DO, FAAO
PM&R/OMM
Pain Clinic 4th Deck
Dept Anesthesia
Naval Medical Center
Portsmouth, VA 23708

Dear Editor:

I am sorry to learn that death has taken another of our standing leaders,

continued on page 23

A New Challenge to Osteopathy

by John Rolles, DO

Editor's Note: *Chris Rolles, son of AAO John Rolles sent this essay to the Academy for publication. This essay was written by Dr. Rolles when he was a junior at the College of Osteopathic Medicine and Surgery in Des Moines, Iowa in 1951. Dr. Rolles passed away November 11, 1994. An "In Memoriam" to him is found elsewhere in this issue.*

In a recent survey* 1.1 percent of all students in our osteopathic colleges expressed their intention of becoming missionary doctors. This percentage, per se, looks small, but the survey states that it represents 16 students, and if all of them fulfill this intention, they will initiate an impressive new movement of osteopathic service.

Medical missionary work is not an entirely new idea to the osteopathic profession. Drs. Elizabeth and John C. Taylor in the reformed Presbyterian Mission at Rourki, N. India; Dr. Robert V. Herbold in the Sudan Interior Mission, Nigeria, W. Africa; Dr. Jennie V. Flemming (retired) in the Central Provinces, N. India and Dr. J. Kenneth Altig (retired) in Peru, have all done outstanding work and have held the professional torch high in the mission field.

When we consider the growth of the osteopathic profession during the last three decades, the number of missionaries seems pitifully small for such an enormous task, but we are are beginning to recognize that these physicians have not only given great service in their chosen fields, but have also unobtrusively laid the foundation of adventurous endeavor. As far as our profession is concerned, they have been pioneers in the highest sense of the word, and their work among underprivilegd people is becoming a great inspiration to the present generation of students.

For many years we have, of necessity, been concerned with "setting our own house in order." Out of all this activity we can see in better perspective our enormous progressive strides in a number of directions. Osteopathic education has been raised to its high present day standards; legislative advances are constantly being reported; scientific research is being carried on at a higher tempo than ever before and the general practitioner has won a well-deserved place as family physician in the community life of the nation. These are some of the advances of which the profession may be proud.

But our advance abroad has not been so spectacular. Although osteopaths are now found in most countries, the greatest concentration of the osteopathic physicians and surgeons is still in the United States and Canada. We feel that we have far more to offer to the need of human suffering than any other group. The time has come, therefore, to make a great new advance. We must think in global terms and recognize that osteopathy has not only a national but a universal application.

There are huge centers of population where the name of osteopathy is completely unknown. We have such an example in India. It is true that the Taylors are working at Rourki, but that is the far north. Further south the people have had no contact with our profession. The same can be said of Central Africa, China, the Islands and other areas of missionary endeavor.

Anyone acquainted with the problem of missionary staffing today will be aware of the acute shortage of missionary doctors. The representative of one of our oldest missionary societies, speaking recently to a group of ministers and laymen, said that young men and women are coming forward in greater numbers now to fill ministerial and teaching posts abroad, but that there was a great shortage of medical candidates. The fact that there is, on the one hand, this serious shortage of doctors to fill numerous mission posts, and, on the other, the expressed intention of sixteen students in our colleges to take up this work, constitutes the biggest opportunity and challenge to the osteopathic profession for many years.

Until recently, the possibility of osteopathic physicians serving in thickly populated areas abroad where no modern medical service exists has not been given serious and constant consideration. Perhaps one of the reasons is that outside the United States adequate recognition is not given to the profession. We must, however, admit that where no osteopaths are practicing, recognition

*The Journal of the American Osteopathic Association. Aug. 1950.

is not likely to be accorded. If osteopathic doctors are appointed by reputable missionary societies, it is certain that recognition will be forthcoming.

We should remind ourselves that not only have we a therapy par excellence, but that that therapy incorporates every up-to-date therapeutic modality and procedure. We claim, rightly, that we have the best, that we are abreast of our scientific times, and that professionally we exist to serve. This service should extend to human need everywhere in the world, and in the field of healing, nothing but the best is good enough. If we seriously consider extending our service in terms of the missionary enterprise, it will place considerable strain on our resources. But a beginning has been made, and the promise of the future, personified in sixteen student doctors, is full of hope.

The determination to extend our borders has come from the right source. Such a determination cannot come through professional council resolutions, however much they may indicate a trend in thinking. The impetus for any such new movement must inevitably come through a sense of calling by individuals, and that is precisely what is happening.

We have reached a point in our history when this outward movement should be given wholehearted backing by the profession; in personal interest, directed thinking, encouragement, and financial support. We must think first of all of these students who, we can be sure, represent the vanguard of a growing movement, and who intend to offer their lives to a work of immeasurable opportunity, but possibly of obscurity. We must also think of the people whom they will serve.

A few weeks ago the announcement was made that two of our colleges had received substantial grants from the Government for cancer research. As soon as I read the notice, a picture flashed into my mind of a traveler's bungalow in India about six years ago. My wife and I, with our two children, had arrived in the evening on our way home from camp in an obscure village area. As we unpacked our bedrolls for the night, a young Muslim came to the bungalow steps and begged us to walk up the road a short distance to see his mother. He said she was very ill, and he wondered whether we could do anything for her. We followed him and found his mother squatting by the roadside. She drew her sari on one side and revealed her left breast, almost completely destroyed by cancer. She was still in her early thirties, but we knew that her chances of life were slim.

Our nearest mission hospital was fifty-six miles away, so we gave mother and son their bus fares and a note to our doctor colleague, and sent them on their hopeless way. Perhaps, if that mother had been found by a doctor in the early stages of the disease she could have been saved. Unhappily, she is one of millions who miss modern scientific care. I wondered, when this research grant was given, whether it could extend its reach through newly trained doctors to some of her people in similar need. The diseases with which any doctor would have to deal are countless, but this illustrates but one more strand in our possible outreaching service. We once had frontiers, but those frontiers have now gone.

Last year, the Student Body of Des Moines Still College of Osteopathy and Surgery unanimously resolved to start a missionary association in the college, with a view to raising scholarships for missionary training and a fund for supporting medical missionary work when students trained at the college are appointed by their Church societies to the Field. The organizing of such an association, calling as it does for the interest and support of many non-collegians, is necessarily slow; but the resolution is fraught with tremendous potentialities. If similar associations are set up in our other colleges, and the present generation of students is given the support of the profession as a whole, it should be possible to guarantee a steady stream of young doctors going out to represent the churches and the osteopathic profession on the mission field.

The growing interest in medical missionary work is in keeping with the origins of osteopathy. Dr. A.T. Still's father toured in the middle West as a Methodist missionary, and Dr. Still himself was closely associated with him in that work. Osteopathy actually sprang into being and was nurtured in a missionary atmosphere. One can imagine the Old Doctor smiling his approval on this renewed trend.

We cannot tell how rapidly the missionary motive will stimulate interest among members of the profession. Whatever our denominational allegiance may be, we at least have this aim in common - to alleviate suffering, to eradicate disease, and to keep men, women and children healthy, irrespective of their color, creed, caste or nationality. We are a part of what Albert Schweitzer has called "The Fellowship of those who bear the Mark of Pain."

I suggest, therefore, that his movement within our ranks, still small, but nevertheless very potent, be studied with all seriousness by every member of our profession: that financial support be given to students who enter our colleges with the assured intention of offering themselves for service in a reputable missionary society: that those who

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are sent abroad as missionary doctors be given an assurance of constant interest and backing from home and finally, that a place be provided on the agenda of every annual Convention of the American Osteopathic Association for the presentation of information regarding the work of osteopathic missionary physicians and surgeons, and our essential part in the missionary motive.

If we become fully conscious of our opportunities and accept this new challenge to osteopathy, we shall add further links to the chain of service started by Andrew Taylor Still. Our profession began from very small beginnings, "a little cloud out of the sea, like a man's hand." Within a relatively short period of time, it has grown to its present proportions. We should have the vision to see the possibility that in 50 years, there will be 10,000 osteopaths in service beyond the borders of the United States, including not only those who are sent out, but also those who are brought here to be trained. In other words, by accepting the challenge and taking appropriate action we can double our strength for service in the next half century.

The passionate tale of man's love/hate relationship with gravity, or...

"WHEN HARRY MET GLENDA"

by Catherine Hayes, DO

Little Harry was conceived and born into Glenda's world. Even before birth, he felt her presence everywhere. Floating in his mother's womb, he accepted her influence unquestioningly, and he trusted her as he trusted all parts of his environment . . . to be kind . . . to be gentle . . . to be loved.

The warm cushion of his amniotic bed, the rhythmic music of his mother's heart and gravity's gentle tug on his rapidly changing form. This was Harry's reality and he knew, deep down in his bones, that these things would never change.

But forty weeks into his life, Harry's fortune took a turn (almost a right-angled turn) as he was evicted, red-faced and screaming from the only world he had ever known. Gone was his ocean bed. Fleeting now was the music of his mother's drum. But constant and demanding was Glenda's pull upon his tiny frame. She alone would be his undeniable companion.

Weeks passed. At first, Harry lay curled against his mother's body. She offered a temporary haven from an onslaught of new sensations....cool skin, spasms of an empty gut and attempts by Glenda to snap his head from his body each time he directly encountered her force.

Who was this Glenda Gravity, and what did she want from him? Harry was beginning to wonder.

Whenever Harry's mother placed him face down in his crib, he managed to turn his head to one side to keep from suffocating. (He'd begun to have a few doubts about his mother as well.) At four weeks, he graduated from the Neonatal School of Hard Knocks, and a face-down Harry found that he was able to lift his head momentarily from the surface of his bed. The first rays of promise brightened his small world. Glenda was strong (irresistible, in fact), but he, Harry Sapiens, would grow stronger. If he could not refuse or escape her influence upon his life, he could, at the very least, meet her demands with courage and with bodily strength to balance against her own.

At twelve weeks, Harry could raise his head and chest by extending his arms. By another month, he could raise his head to a vertical axis and turn it easily from side to side. No longer did his head lag when his mother pulled him to a sitting position. Yes! Harry was developing in spite of and because of Glenda's influence. The rounded curve of his neck began to change slightly; his muscles learned to play with Glenda. He was starting to enjoy the challenge. By six months, Harry could support his own weight

(a gift from Glenda) on extended legs which he soon learned to flex while remaining balanced.

Of course, sitting alone was still difficult without the lumbar lordosis he had yet to develop. Harry's spine still curved in a gentle "C" form the rolls or fat at his neck to his lower diaper region.

Eventually, time, upright posture and Glenda's constant prodding and supervision changed Harry. After two years, he did have a lumbar lordosis, although only a small one, with a little protruding belly on the opposite side which nirrored its curve. Harry wore his curves proudly. He had earned them degree by slow degree. Glenda might be his companion, but she would not rule his life without protest. Harry was developing back bone.

Harry and Glenda . . . theirs was a long and event-filled relationship. At times there was harmony and perfect balance when they seemed to float through life, dancing along the path together in perfect step with one another. In those moments, you would never guess that there had been rougher roads when Harry's toe had snagged a rock and he had gone spiraling in Glenda's direction crashing into anything along the way. Often under those circumstances, Harry was less tolerant of Glenda's presence. He even called her names unbefitting a life-long companion. But Glenda never waivered. She understood her role in Harry's life, and she played it perfectly.

After all, she was the immortal one; she felt no pain; she had no scars. Those fell to Harry. It was he who suffered in their relationship, but it was also he who grew and changed. Glenda could not grow or change. She was stuck...a prisoner of her own magnetic force.

As the years passed, Harry's body began to reflect all that Glenda had meant to him. The broken leg he sustained playing football at twelve and the resulting curves in his back when his fractured leg grew longer than the other one. The long hours he spent leaning over his desk at work while resisting Glenda's pull on his neck and shoulders. The fender-bender which placed the first scratch on Harry's new Subaru and which added one more twist to the body restrained by a shoulder harness. The accumulated residue of years of Big Mac's on the run in a body that gave up jogging long ago.

Now as Harry moves through space ruled by Glenda's guiding force, he is truly a motion picture. His body recounts all of the good and bad times he has spent with her.

Harry's story is not so different from yours or mine. We, too, have met Glenda and have known her attraction throughout our lives. We, too, have suffered, have endured and have grown stronger for her influence. Our bodies also reflect the novel or short story or limmerick of our lives. Will there someday be one with the eyes and ears and hands to read our stories? Will that one be an osteopathic physician? ❑

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continued from page 19

Donald Siehl, DO, FAAO. The notice in the *AAO Newsletter* reminded me of a 1981 memo that Don sent to members of the Academy who may be asked to serve in instructional capacities for various organizations and committees of the osteopathic profession, in the area of osteopathic orientation, structural diagnosis and manipulative treatment. He stated:

"We must realize that in our effort to get more people interested in structural diagnosis and manipulative treatment and using these in practice, we must keep in simple enough so that they can accommodate and use the methods easily. Those of us who are especially proficient in these areas sometimes forget that many physicians can use osteopathic methods in a part of their practice and use it effectively although not as proficiently as we may do. If each osteopathic physician can do just one or two things additional in this area to what he is now doing, we will accomplish something. Then, he has his interest aroused and is motivated to get additional courses under Academy or other sponsorship.

I think we should remember that there is still a place for general osteopathic manipulative treatment for many common conditoins, as well as for traumatic conditions. There is still a place for regular osteopathic manipulative treatment as prophylactive or preventative treatment. There is still a place for the relaxing effect of such treatment, or for the stimulatory effect of such treatment, properly applied.

We anticipate that in the next two or three years many members of the Academy will be asked to participate in various programs as instructors in osteopathic methods. We must get our messages across. We must keep things relatively simple to do it. We must not overwhelm our doctors with our own expertise."

I hope you will see fit to publish it in *The AAO Journal.*

V.C. Hoefner, Jr., DO, FAAO
Grand Junction, CO

Osteopathy Goes Platinum in Music City USA

American Academy of Osteopathy

1995 Annual Convocation

March 22-25, 1995

Opryland Hotel Nashville, Tennessee

Program

Wednesday, March 22, 1995

7:45 - 8:00	Welcome Ann Habenicht, DO, Program Chairperson Eileen DiGiovanna, DO, FAAO, AAO President
8:00 - 8:45	Neuroanatomy of Pain Frank Willard, PhD
8:45 - 9:30	Trauma Vectors Judith O'Connell, DO
9:30 -10:00	**Break/Exhibits**
10:00 -10:45	Physiatrist's Role in Chronic Pain James Lipton, DO, FAAO
10:45 -11:30	Reflex Sympathetic Dystrophy & Sympathetic Dystonia Robert Kappler, DO, FAAO
11:30 -12:00	Psychiatric Aspects of Chronic Pain Andrew Lovy, DO
12:00 - 1:30	**Lunch**
1:30 - 3:00	**Workshops** A-Back to Basics OMT: HVLA for Chronic Pain Robert Kappler, DO, FAAO B-Back to Basics OMT: Facilitated Positional Release Stanley Schiowitz, DO, FAAO C-Back to Basics OMT: Ligamentous Articular Release M. Denise Speed, DO and Conrad Speece, DO D-Torque Unwind (runs entire PM) Elaine Wallace, DO E-Fellows Forum FAAO and NUFA Harold Magoun, DO, FAAO
3:00 - 3:30	**Break/Exhibits**
3:30 - 5:00	**Workshops** F-Back to Basics OMT: HVLA for Chronic Pain Robert Kappler, DO, FAAO G-Back to Basics OMT: Facilitated Positional Release Stanley Schiowitz, DO, FAAO H-Back to Basics OMT: Ligamentous Articular Release M. Denise Speed, DO and Conrad Speece, DO I-Education Committee Forum Boyd Buser, DO, and AAO Education Committee

New Horizons in Pain Management

Thursday, March 23, 1995

7:45 - 8:00	Morning Convocation Update Ann Habenicht, DO
8:00 - 8:45	Pharmacology in ChronicPain William Elliott, MD, PhD
8:45 - 9:30	Oh, No, Fibromyalgia! Mark Cantieri, DO
9:30 -10:00	**Break/Exhibits**
10:00 -10:45	Chronic Foot and Ankle Pain Thomas Ravin, MD
10:45 -11:30	Discogenic vs. Non-Discogenic Pain Manuel Pinto, MD
11:30 -12:00	Acupuncture in Chronic Pain Kenneth Lubowich, OMD
12:00 - 1:30	**Lunch**
1:30 - 3:00	**Workshops** K-Back to Basics OMT: Muscle Energy Boyd Buser, DO L-Back to Basics OMT: Counterstrain John Glover, DO M-Torque Unwind (runs entire PM) Elaine Wallace, DO N-Treatment of Chronic Foot & Ankle Pain Thomas Ravin, MD O-Faculty Development: The Physician as a Researcher, Documenting Outcomes Research John Hohner, DO
3:00 - 3:30	**Break/Exhibits**
3:30 - 5:00	**Workshops** P-Back to Basics OMT: Muscle Energy Boyd Buser, DO Q-Back to Basics OMT: Counterstrain John Glover, DO R-Treatment of Chronic Foot & Ankle Pain Thomas Ravin, MD S-Faculty Development: How to Represent Osteopathy to Third-Party Payors Judith Lewis, DO & AAO Medical Economics Cmte

Friday, March 24, 1995

7:45 - 8:00	Morning Convocation Update Ann Habenicht, DO
8:00 - 8:45	Nutritional Needs in Chronic Pain Stephen Elsasser, DO
8:45 - 9:30	Reducing Gravitational Strain Pathophysiology Michael Kuchera, DO, FAAO
9:30 -10:00	**Break/Exhibits**
10:00-10:45	Chronic Pelvic Pain Melicien Tettambel, DO, FAAO
10:45-12:00	Exercises for Chronic Pain interactive lecture with audience participation Karen Gadja, DO
12:00-12:30	New Ideas Forum (two 15-minute presentation time slots available; prospective presenters must submit outlines to the EDCOM for selection)

Saturday, March 25, 1995

7:45 - 8:00	Morning Convocation Update Ann Habenicht, DO
8:00 - 8:45	Anesthesia's Role in Chronic Pain Management Larry Harker, DO
8:45 - 9:30	Migraine Cephalgia Hal Pineless, DO
9:30 -10:00	**Break/Exhibits**
10:00 -10:45	Facial Pain: Bell's Palsy & Trigeminal Neuralgia William Wyatt, DO
10:45 -11:30	Chronic Cervical Spine Pain Karen Steele, DO
1:00 - 5:00	Conclave of Fellows

Ann Habenicht, DO,
Program Chairperson

CME Hours:
25 Hours Category 1-A

Challenges and Burdens
Continued from page 12

Further, I believe that the Academy must not only actively support undergraduate fellowships and post-graduate residencies, but also we must begin to advocate the publication of research papers as a requirement so that these fellowships and residencies can be successfully completed. I know personally that if I had been forced to be as rigorous in doing research as I was in my teaching, I would have had an even greater influence on the profession than I have had. I think all the osteopathic principles and practice fellows and osteopathic manipulative medicine residents should be invited and even mandated to attend these research tutorials.

The Academy has, as I mentioned, been reinvigorated in its study of the osteopathic approach to visceral diseases. Again, I believe that the concept of the tutorial done several times a year over a five or seven year period can greatly influence the next generation of osteopathic teachers. My second recommendation is that we should have a series of two and a half to three-day tutorials on diagnosis, management and integration of osteopathic principles into visceral diseases. Dr. Mike Kuchera has produced an excellent textbook on this matter that could be the starting point. Reviews of the relevant anatomy, physiology, conventional history taking and conventional physical examination with appropriate differential diagnosis, combined with the unique aspects of osteopathic principles could easily fill such a program. I believe that these could be divided into a cardiopulmonary program, a GI/GU program, a third for HEENT; a fourth for rheumatology and endocrinology and a fifth for neurology/pediatric. Within the framework of these tutorials, one area in which I believe the Academy can pursue pre-eminence centers around an idea that I have been working on for the past several years and which I presented to the Academy several years ago when I lectured on somatic components of visceral diseases. I believe that there are many, many diseases that can present to us in a musculoskeletal fashion that are not primarily musculoskeletal. I presented a paper on a patient with hemochromatosis that presented as lumbar strain superimposed on spinal arthritis. A second patient, who turned out to be in the early stages of Guillain-Barre Syndrome, presented with tender points of the shoulder girdle. A review of the literature revealed that those tender points were in reality early inflamed nerve endings. A case of hypothyroidism presented to my practice as fibromyalgia with multiple trigger points, and I discussed several other visceral conditions that had musculoskeletal involvement. Indeed, we can learn more about underlying osteopathic principles if we have a good understanding of these disease presentations. For example, last year a patient presented with myalgias, arthralgias, ligamentous laxity and scoliosis, and I was able to diagnose Marfan's Syndrome. Upon review of the literature on Marfan's, I learned something that enhanced my understanding of osteopathic principles. In an article in *Heart Disease and Stroke*, September, 1994, it is noted that in Marfan's disease, "dural ectasia (which is an expansion of the dural sac with erosion of the surrounding vertebral structures) was explained as arising from the continuous, and somewhat pulsatile pressure of the cerebral spinal fluid on a connective tissue membrane that is weakened by a defect of extracellular matrix."[8] This statement certainly helps to support some of our underlying concepts of osteopathy in the cranial field, yet it appears in a journal of cardiovascular medicine concerning a disease of connective tissues. It should be noted that the negative effect of the CSF pressure on abnormal connective tissue begs the question. What is/are the positive effect(s) of the pulsatile pressure of the CSF on normal connective tissue? More than any other specialty, with the exception perhaps of nutrition, we need to seek our answers from a wider, larger volume of sources, for we affect or can be affected by all other specialties. And, as we begin to further understand the musculoskeletal manifestations of other diseases, we may enhance our knowledge of underlying principles that support osteopathic philosophy, e.g. why do patients with mitral valve prolapse have such a high incidence of congenital rib cage and thoracic abnormalities? And how does the etiology of carpal tunnel syndrome help promote under-standing of osteopathic principles? You need to read the February, 1994 *Journal of Radiology*[9] that identified mechanisms responsible for carpal tunnel syndrome. They used a dynamic contrast enhanced MRI imaging to evaluate the circulation to the median nerve. And as we would have predicted through osteopathic principles, two problems were occurring. In the neutral position, they noted that there was nerve edema secondary to circulatory congestion, and that in the flexed or extended position, that there was ischemia to the median nerve. This certainly helps support A. T. Still's notion that the rule of the artery is supreme and also supports the lifetime work of Gordon Zink who contended that venous and lymphatic drainage are necessary for proper functioning of all tissues within the bodies. This research also makes me urge the Academy to support the use of technology in our clinical settings to enhance our understanding

of osteopathically relevant conditions. For example, again citing carpal tunnel syndrome[10], Dr. Sucher's research with MRI of the wrist shows the improvement in the osseous arthrodial anatomy of the carpal canal with an appropriate program of osteopathic manipulative management and exercise. Without such objective documentation such as the above, it will be hard for us to achieve the preeminence that we want by the year 2000. Additionally, if we look at these two papers, it becomes clear that objective proof with state of the art technology supports the osteopathic principle that where there is osseous arthrodial dysfunction. We also will find myofascial, circulatory and neuronal changes. Within the next few years, P.E.T. scans will become more available and can be utilized to help us enhance our understanding of osteopathic principles. Furthermore, I would urge the Academy to stay abreast of current medical literature so that we can judge concepts that do not support our osteopathic principles. An example of this would be the increasing emphasis on the role of inflammation in the pathophysiology of asthma as opposed to our traditional primary emphasis on the neurological factors involved in asthma. If we are to have a broad perspective on medicine, then we can search out such articles as "Neural-immunological interactions in asthma" by Bradley Unem, MD published in *Hospital Practice*, February, 1994.[11] He states "With respect to pathology, nerve stimulation can itself elicit the key features of airway inflammation including vasodilatation, plasma extravasation and leukocyte infiltration." Similar statements can be found in early 20th century osteopathic research but are not known by Dr. Unem. His conclusion, however, is more in line with traditional osteopathic philosophy in that the immunological and neural systems are closely interrelated and that asthma, rather than being immunologic or neurologic, may, in fact, be the product of the two systems malfunctioning in conjunction. Ofcourse, he misses the osteopathic link between the musculoskeletal system and the neurological and immunological systems that truly underlies our profession. My last recommendation for the vitality of the osteopathic profession and the Academy is for Academy members to involve themselves on the boards of their medical schools and/or hospitals. I have for the past 11 years sat on the board of the New York College of Osteopathic Medicine. I have been a happy and non-compromising advocate for the utilization of osteopathic principles throughout the curriculum. I was thrilled this past year to be able to sign off and supply the money for a research grant to two of our professors to study aspects of the craniosacral mechanism. I have also successfully fought forces who wished to raid our endowment funds and to use them for the general purposes of the university rather than for the specific purposes of osteopathic medical education. We, therefore, not only need friends in higher places, we also need you in higher places, if we are to achieve the goals that Thomas Northup set out for the Academy in 1937 when he said that "the foremost object and purpose of this association is to develop a science and art of osteopathy to the fullest possibilities its principles justify."

"the foremost object and purpose of this association is to develop a science and art of osteopathy to the fullest possibilities its principles justify."

Again, my deep thanks and appreciation for this great honor.

References

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2. Ibid p. 61

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10. Sucher, B. Myofascial manipulative release of Carpal Tunnel Syndrome: Documentation with Magnetic Resonance Imaging. JAOA. 93:12 Dec. 1993, p. 1273-1278.

11. Unem, B. Neural-Immunologic interactions in asthma. Hospital Practice. Feb. 15, 1994. p. 59-70. ❑

appeared normal. Evaluation of pelvic symmetry in the standing position failed to reveal any abnormalities nor any abnormal motion characteristics in that region.

Assessment

1. Acute cervical and thoracic somatic dysfunction.
2. Recurrent cephalgia secondary to muscle contraction and craniosacral somatic dysfunction.
3. Chronic cervical and thoracic somatic dysfunction.
4. History of bilateral radial tunnel release and right carpal tunnel release.

Patient was treated initially with extensive indirect myofascial release and indirect fascial ligamentous release as tolerated. She did note some subjective improvement with increased cervical range of motion noted. Patient was seen on a weekly basis with progressive improvement noted and more extensive treatment being done with each visit. Within four weeks the patient had noticed that she was sleeping better and the headaches were becoming less severe.

Within an additional four weeks, the headaches had resolved completely, and there was much less subjective complaint of pain in the cervical and thoracic regions. As the patient noticed these improvements, more extensive evaluation and treatment was done with each subsequent visit. Additional findings in the lumbosacral region revealed rotation of the thoracolumbar junction to the left, right rotation of the lumbosacral junction and a right torsion of the sacrum. Additional indirect myofascial treatment was provided to these areas and on further visits direct mobilization with HVLA to the cervicothoracic, mid-thoracic, thoracolumbar and lumbosacral regions was also done on a gradually increasing basis. Following direct treatments to the upper thoracic region, the patient noticed some decrease in the amount of arm pain and was able to tolerate more activity with the arms. As she tolerated activity with the arms, additional treatment in the form of indirect myofascial release to all areas of the upper extremity was initiated and continues at this time with improvement noted with each follow-up visit. Although the patient has not returned to "normal" activities, she has been progressively increasing her activities and becoming more productive.

Discussion

This case illustrates the importance of the axial skeleton and rib cage in normal functioning of the upper extremities. Additionally, we see that a neurological deficit demonstrated by EMG testing and attempted correction with surgery failed to alleviate the symptomatology that the patient was experiencing.

From a biomechanical aspect, the repetitive motion that this patient used during her employment involved repeated, forceful use of the right upper extremity. The only boney attachment to the thoracic cage is by way of the clavicle.

Posterior stabilization of the shoulder joint comes from muscular attachments. In an effort to stabilize the scapula against the ribs at the gliding scapulothoracic articulation, hypertonicity of the musculature develops with adverse effects of the thoracic and cervical regions. There can be many factors involved which produce symptoms in the upper extremities. They include distortion of the cervicothoracic junction with direct irritation of the nerve roots of the brachial plexus from CS through T1. This distortion of the thoracic inlet or superior thoracic aperture can further influence the branches of the brachial plexus as they emerge from the thoracic inlet.

Since compromise of this area will also affect venous and lymphatic flow out of the upper extremities, the normal environment of the upper extremities at both the muscular and neurovascular level will be compromised, producing an additive effect of what might be interpreted as a relatively minor disturbance of normal nerve function.

It is probably the combination of these multiple etiologies that is able to produce the severe type of symptoms that we have seen, and the concept of multiple etiologies is reinforced by the fact that direct decompression of affected radial and median nerves failed to produce resolution of symptoms.

This structural functional relationship in the cervical and thoracic region is important in devising a treatment plan for these types of symptoms. By restoring the axial components to as near normal function as possible, we not only relieve any direct action on nerve roots, but also provide a more normal functional relationship with the upper extremity.

In this instance, treatment aimed at the muscular attachments of the scapula not only relieves stress in the cervical and thoracic regions, but would also allows for increased motion of the upper extremity. By decreasing the amount of tone in the posterior axillary fold, we also would begin to allow better proximal flow of venous and lymphatic congestion. Increased motion and muscular activity in the upper extremity would allow for a better peripheral pumping-type action to move fluids.

The chronic compensatory changes in the cervical and thoracic regions also appear to have had a profound affect on recurrent headaches. The direct effect of muscular contraction can cause venous congestion of the head as well as provide extrinsic forces contributing to and maintaining a sphenobasilar strain, again providing multiple etiologies for the recurrent headaches. As these areas gradually returned to a more normal, structural, functional relationship, the symptomatology improved. This is significant in this case because with the chronic upper extremity and back pain, the patient's outlook for a productive life was becoming seriously affected. As symptomatic improvement was made, a change in her attitude toward her chronic pain was also noticed. With the improvements noted, attempts to further resolve some of the functional abnormalities of the upper extremities could then be approached. By approaching the extremities with techniques involving indirect myofascial release, it is hoped that gradual improvement in the functional capacity could be attained. Extensive fascial continuity from the upper extremity extends from direct cranial attachments as well as throughout the cervical, thoracic and lumbar areas. Restoration of the myofascial elements in these regions to a more normal functional relationship should allow eventual release of fascial restrictions into the upper extremity. Of importance here also is surgical disruption of fascial layers at the elbows and wrists can also affect the continuity and interrelationship in normal functioning of these areas. They may prove to be continued sites of irritation and be the focus of pain, but hopefully, they will respond to indirect release over a period of time. ❑

Advanced Percussion Vibrator Course
May 13-14, 1995

Speakers: Robert Fulford, DO and Richard Koss, DO
Course Location: The AAO Headquarters
Indianapolis, Indiana

Saturday, May 13, 1995
8:00 am - 5:00 pm

Warning
- Billing problems, insurance companies
- not using the percussion hammer on every patient

Quote - Streams of human energy;
R.C. Fulford, DO

Review of the use of the motor; tune, intention, resonance - more detail.
Richard Koss, DO

Rhythmic balance interchange;
- Nature, motor, give-regive, action-reaction, desire, decisions, balance-rebalance information-knowledge
R.C. Fulford, DO

History - illness/trauma; R.C. Fulford, DO
(Progressive sensory-motor cortex syndrome; A.T. Still - tree of life, Entropy-2nd Law of Thermo-dynamics, Law of Specificity, metabolism (degeneration/ regeneration); Diagrams of string - Bentov, Astrology- houses

BREAK

To Tables
Knee - with triangle
Ankle
Foot- Arc of foot, reflexology chart

LUNCH

Exercises

To Tables
Femur

Diagrams of egg - Burr

To Tables
Pelvis - standard procedures galant reflex - empty the pelvic bowl, Dr. Still page 196, *Philosophy and Mechanical Principles*
Percuss coccyx and palpate abdomen

Sunday, May 14, 1995
8:00 am - 4:00 pm

Vibration paper
Resonance
Solar Plexus Paper
Shock release
Linea alba, taffy pull, triangle on chest, T_4 and xyphoid, Percussion on xyphyisternal junction, left chest to xyphoid, Percussion - double triangle (Rt leg and Lt arm)

BREAK

To Tables Percussion of skull
Deltoid recesses
Parietal emenance
Asterion
Occipital protuberances
Fontenelle
Zygoma
C_3
Manipulation of skull

LUNCH

Breath paper
Piston Breathing
Percussion - Sternal Angle
Lower sternum
Maniulative technique-
Sternum and occiput

Registration Form

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$79 room rate; 3850 DePauw Blvd., Indianapolis. Reserve now to guarantee room availability. Course is being held on busy hotel week-end.

Classifieds

New Orleans

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

OMM Externship Available

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

OMM/Physical Medicine Physician

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

OMM Practice Opportunities in Southeast Michigan

Rural or urban solo with colleague support hospital teaching, consults established cranial study group. Respond in writing to Alice R. Shanaver, DO, 3233 West Road, Trenton, MI 48183.

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Family practice and OB/GYN openings in various locations of rural, not-for-profit healthcare corporation. Small, mountain communities serving total populations of up to 50,000 people. Hospitals of 50-200 beds. Choose salary plus benefits or minimum income guarantee plus productivity incentive. We take the business worries, you see the patients. Sites also available in the VIRGINIAS. Experience the satisfaction and security of life in a small town plus APPRECIATION FOR YOUR WORK. Send CV to or call Greg Davis, Appalachian Regional Healthcare, Inc., P.O. Box 8086, Lexington, KY 40533. (800) 888-7045 or (606) 281-2537 collect. EOE M/F

Advertising in *The Journal* of the American Academy of Osteopathy's classified section is $1.00 per word

Wanted: OMT fellows and/or osteopathic medical students

Warren Hospital Family Practice Residency Program in western New Jersey has one of the strongest osteopathic components available.

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Calendar of Events

MARCH

22-25
AAO Annual Convocation
Program: New Horizons
in Pain Management
Opryland Hotel
Nashville, Tennessee
Hours: 25 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

APRIL

6-9
Occupational and Preventive Medicine
AOCOPM Midyear Conference
Hotel Washington
Washington, DC
Hours: 40 Category 1-A
Contact: AOCOPM
(404) 952-5651

22-23
Sutherland's Methods for Treating the Rest of the Body
Hours: 16 Category 1-A
Contact: Conrad Speece, DO
10622 Garland Road
Dallas, TX 76218
(214) 321-2673

27-29
Annual Conference of the
• College of Osteopathic Healthcare Executives
• Association of Osteopathic Directors and Medical Educators
• National Osteopathic Women Physicians Association
The Ana Hotel
San Francisco, CA
Contact: (202) 686-1700

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

MAY

13-14
Dr. Robert Fulford's ADVANCED Percussion Vibrator Course
AAO Headquarters
Indianapolis, Indiana
CME Hours: 15 Category 1-A
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

JUNE

12-16
Intermediate Course of the Expanding Osteopathic Concept in the Cranial Field – Viola Frymann, DO, FAAO, course director
Osteopathic Physicians & Surgeons of California – sponsor
Shilo Inn Pomona Hilltop Suites Hotel
Pomona, California
Hours: 40 Category 1-A
Contact: OP&S of California
(916) 447-2004

16-18
Annual Meeting
Colorado Society of Osteopathic Medicine
Snowmass Conference Center,
Snowmass at Aspen, Colorado
Hours: 18 Category 1-A
Contact: Patricia Ellis
(303) 322-1752 or
FAX: (303) 322-1956

17-21
Basic Course in Osteopathy in the Cranial Field. . . and
23-25
Cranial Academy Annual Conference
Arizona Biltmore
Phoenix, Arizona
Contact: The Cranial Academy
(317) 879-0713

SEPTEMBER

15-17
Visceral Manipulation Course
Indianapolis, Indiana
CME Hours: 25 Category 1-A
Contact: Diana Finley, AAO
Associate Executive Director
(317) 879-1881

18-22
Basic Course of the Expanding Osteopathic Concept Into the Cranial Field – Viola Frymann, DO, FAAO, course director
Osteopathic Physicians & Surgeons of California - sponsor
Shilo Inn Pomona Hilltop Suites Hotel
Pomona, California
Hours: 40 Category 1-A
Contact: OP&S of California
(916) 447-2004

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