

THE AAO

JOURNAL

 A Publication of the American Academy of Osteopathy

VOLUME 6 NUMBER 1 SPRING 1996

In this Issue:

1995 Scott Memorial Lecture...9

A functional approach to heel lift therapy...13

Sacral shear: Review and a new treatment
method for OB patients...16

Ram of Reason

About the cover...page 5

Fifth Annual OMT Update

*Application of Osteopathic Concepts in Clinical Medicine
plus Preparation for OMM Boards*

September 26-29, 1996

Grand Floridian Hotel, Orlando Florida

Registration Form

July 26-30, 1996

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2/AOA Journal

FEES:

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AAO MEMBERS DO/MD	\$475.00
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CME HOURS:

4 days; 22 hours; AOA Category 1-A
21 hours; AAFP Approved
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offered by the AAO)

Program Chairperson:

Ann Habenicht, DO, CSPOMM

PROGRAM

THURSDAY, SEPTEMBER 26

Opening Reception
Overview of the Course; "Applications of osteopathic concepts in clinical medicine... What to use: When and Why"

"Cranial Osteopathy"

"Counterstrain"

"Myofascial Release"

"Visceral Manipulation"

"Muscle Energy"

"High Velocity/Low Amplitude"

"Exercise Prescription"

FRIDAY, SEPTEMBER 27

Breakfast Lecture Coding Update –
Getting Paid for What You Do"
"Thoracic Trouble-shooting" (to include various modalities approach - HVLA, ME, counterstrain, indirect-MFR & cranial) Skills Session: Thoracic
"Cervical/Suboccipital Troubleshooting"
Skills Session: Cervical/Suboccipital –
Wrap-Up Session: (Summary)

SATURDAY, SEPTEMBER 28

Breakfast Lecture Coding Update -- Part II
"Upper Extremity Troubleshooting"
Skills Session: Upper Extremity
Lecture Lumbar/Pelvis Troubleshooting"
Skills Session: Lumbar/Pelvis
Wrap-Up Session: (Summary)

SUNDAY, SEPTEMBER 29

Breakfast Lecture—Coding Update Part III
Lower Extremity Troubleshooting"
Skills Session: Lower Extremity
Preparation for Manipulative Boards –
Case Study Preparation –
"How to write them"
Written Exam Prep –
"What to expect"
Oral Prep –
"What to expect & how to do it"
Individual Troubleshooting
**** Alternate Program ****
Sports Medicine – Extremity Review

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Spring 1996

American Academy of Osteopathy

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1995-1996

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THE AAO JOURNAL

A Publication of the American Academy of Osteopathy

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

From the Editor	5
<i>by Raymond J. Hrubby, DO, FAAO</i>	
Message from the President	6
<i>by Boyd R. Buser, DO</i>	
Message from the Executive Director	7
<i>by Stephen J. Noone, CAE</i>	
AAO Calendar of Events	8
Scott Memorial Lecture, 1995: Mind, machinery, and manipulation	9
<i>by Melicien A. Tettambel, DO, FAAO</i>	
A functional approach to heel lift therapy	13
<i>by Kenneth H. Johnson, DO</i>	
Sacral Shear: Review and a new treatment method for obstetrical patients	16
<i>by Robert C. Treadwell, UTF and Warren W Magnus, UTF</i>	
Letter to the Editor	18
<i>by Charles H. Cummings, DO</i>	
Classifieds	21
Letter to A. T. Still	23
From the AOBSPOMM Files	24
<i>by John M. Jones, III, DO</i>	
From the Archives	31

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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. Letters must be signed by the author(s). No letters will be published anonymously, or under pseudonyms or pen names.

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.

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1. Type all text, references and tabular material using upper and lower case, double-spaced with one-inch margins. Number all pages consecutively.
2. Submit original plus one copy. Please retain one copy for your files.
3. Check that all references, tables and figures are cited in the text and in numerical order.
4. Include a cover letter that gives the author's full name and address, telephone number, institution from which work initiated and academic title or position.
5. Manuscripts must be published with the correct name(s) of the author(s). No manuscripts will be published anonymously, or under pseudonyms or pen names.

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

From the Editor

by Raymond J. Hruby, DO, FAAO



For a long time into my adult life I had a dislike for the subject of history. I guess it was because I had to study so much of it when I was in school, and because I had difficulty connecting the study of so much history with my everyday life experiences. After all, who would want to live in the past? Don't we live in the continuous present, with an eye toward the future? What's past was past, as far as I could see, and had nothing to do with anything.

Now this will not seem profound to those of you who realized this long before I ever did, but over time I began to realize that history WAS important. Every person, society, and organization has a history, and the current states of these entities are shaped very much by their histories. Knowing the history of things and people makes understanding the current state of affairs easier, and makes for more reliable planning for the future. So now I try to keep a closer eye on the events that are constantly shaping our world.

I think the same ideas apply to the study of osteopathic medicine. Yes, there are a lot of things we have to learn about when we study to become osteopathic physicians. We must learn as much as we can about basic sciences, clinical sciences, diagnosis and treatment. As DOs we must learn about osteopathic philosophy and concepts and how to apply them in our patient care. We must also become skilled in our unique osteopathic manipulative methods in

Lessons from history

order to fully carry out our roles as osteopathic physicians.

It seems to me though, that few osteopathic physicians ever develop a real knowledge of the history and development of our profession. We don't do much to teach our students about this either. I would imagine that most first-year students get at least an introductory lecture or two on the history of the osteopathic profession, but not much more. I know of no school that requires students to read any A. T. Still's writings, or any of the other literature developed by the early pioneers of the profession. (Note: If I am wrong about this, perhaps some of you could update me).

As for me, studying about the history of the osteopathic profession has given me insight as to why some things are the way they are these days. I have grown to have a stronger sense of who I am and where I belong within the profession. Reading the works of A. T. Still and some of the first DOs has given me a feel for what they were really thinking, what they were trying to accomplish and the kinds of obstacles they faced. Why did Doctor Still invent osteopathy in the first place? Read his books and you will understand.

So, what should anyone read if he or she were interested in learning more about osteopathic history? Well, I would suggest starting with the works of Doctor Still himself: *The Autobiography of A. T. Still*, *Philosophy of Osteopathy*, and *Osteopathy: Research and Practice*. If you'd like more insight into the life and times of Doctor Still and his family, read *Andrew Taylor Still*, by Carol Trowbridge, and *Frontier Doctor*,

Medical Pioneer, by Charles E. Still, Jr. All of these texts are available from the AAO office, and they'll be glad to send you a price list.

As you read these books, you will learn about the early pioneers of osteopathic medicine, such as Hulett, Hazzard, McConnell, Tasker, Hildreth, Sutherland, and others who also wrote extensively about osteopathy. You will learn of the great amount of research done by people like Burns, Korr, Denslow, Cole and so many others. There is a wealth of information here, and getting familiar with some of it will give you a sense of the depth and breadth of the profession like you've never before experienced. Give it a try. I think you you'll like it! □

About the cover

"While in that sleep I dreamed that an old ram of great power hit me a jolt on the side of the head, and sprawled me out full length. I awoke, and looking around, found it was no dream, but a reality, and the old ram was backing out to jolt me again. But he had put so much electricity into my head and legs that I climbed up the tree like a kangaroo.

Then I began to realize that a man must use his head and legs if he wants to succeed in any enterprise."

Autobiography of A. T. Still, page 356.

Message from the President

by Boyd R. Buser, DO

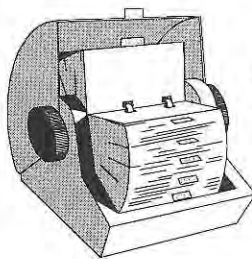


We all learned about the history of osteopathy in the United States during our time in osteopathic medical school. We know about A. T. Still's struggle to create the new profession and the challenges that the profession has met over the years. It was not until 1973 that DOs achieved full unrestricted licensure in every state. Our profession now enjoys unprecedented acceptance in the arena of American health care. While American DOs were fighting for this acceptance, osteopathy was developing along different paths in other countries. Individual DOs have had contact with osteopathic practitioners in Europe for many years. They have taught courses and offered advice to practitioners who were attempting to gain acceptance in their countries. These contacts were accomplished on an individual basis by the physicians involved. As interest in osteopathy grew, the Academy began to receive requests for membership from these practitioners as well as attendance at our medical education programs. During my years as Academy president-elect, it became clear to me that the Academy needed to develop mechanisms to more formally address our relationship with these groups. I proposed the creation of an International Affairs Committee, which the Board of Trustees adopted. The charge to this new committee was to collect information about education and practice of osteopathy in foreign countries, and to make recommendations to the Board of Trustees regarding the Academy's official relationship with these groups.

It soon became clear that osteopathy in Europe was a diverse practice, unregulated by the European governments. It was not until 1993 that the "Osteopath's Act" in Great Britain was passed; the first official recognition of the practice of osteopathy in Europe. The degree, DO, in Great Britain and Europe stands for "Diploma in osteopathy" not "Doctor of Osteopathy" as it is in the U.S., and the practice of osteopathy in Great Britain is restricted to manipulative approaches. Due to the lack of legal recognition and regulation in the rest of Europe, many different schools with varying curricula offer diplomas in Osteopathy, and practitioners with a wide variety of training declare that they are practicing osteopathy. These are some of the problems which the Academy's International Affairs Committee is attempting to sort out.

There is also interest by the medical community in Europe in receiving recognition for osteopathic training by physicians with full licensure. After years of indifference to the development of osteopathy in other countries, the American Osteopathic Association is now becoming more active in this arena. Drs. Mike Kuchera, Phil Greenman and myself, recently met with Doug Ward, PhD and members of the AOA Board of Trustees to discuss this issue. The result of that meeting is a resolution to the AOA Board of Trustees recommending establishment of an International Affairs Committee at the AOA level.

As part of the evolution of these processes, I have convened an international forum at the upcoming AAO Convocation in Atlanta. I have invited representatives from numerous countries including Australia, Canada, Japan and many European countries, representing both physicians of full licensure and restricted scope practitioners. This action is consistent with the Academy's long range plan to establish itself as the worldwide authority on education in the practice of osteopathy. It is my hope that this international forum will help us take another step in that direction. □



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Message from the Executive Director

by Stephen J. Noone, CAE



Recently, I was reflecting on the progress of the Academy in advocating appropriate reimbursement for unique osteopathic manipulative medicine services by third-party payors. Although I outlined the Academy's efforts over a year ago in *The AAO Newsletter*, I believe it would be enlightening to review again the Academy's continuing strategies in addressing this critical concern of the membership. I am impressed with the scope

and depth of our accomplishments on behalf of the profession.

The AAO leadership first addressed this matter in its initial long range plan adopted by the Board of Governors in March 1992. First of all, the Board of Trustees authorized the publication of a "coding packet" which provided AAO members with basic instructions on coding and documenting osteopathic manipulative treatment. While by today's standards some may rate the packet as a crude prototype in organizing OMT coding and reimbursement issues, it certainly provided valuable assistance to individual DOs while at the same time serving as a catalyst for the leadership's direction and planning in this arena.

The Education Committee followed with routine integration of coding workshops at the annual AOA Convention and the annual AAO Convocation. More recently, the Committee has charged chairpersons to include coding and reimbursement updates in all educational programs sponsored by the Academy.

At the 1993 AOA House of Delegates meeting, the AAO leadership pressed for the creation of a coding/reimbursement panel which would be charged with the development of a comprehensive resource on OMT coding. AOA President **Lawrence Bouchard** subsequently appointed a task force which ultimately created the *AOA Coding Instructional Manual*, coincidentally published at the same time as the American Medical Association included separate OMT codes in its 1994 *CPT Manual*.

Under the leadership of Chairperson **Judith Lewis**, the Osteopathic Medical Economics Committee has developed in the last few years a variety of resources to assist Academy members with coding and reimbursement issues in their offices. The group first recommended the creation of a *Bureau of Experts* comprised of a cadre of AAO members who could serve as trained and experienced authorities in OMM for legal depositions, patient chart reviews, or court testimony as expert witnesses.

The January 1996 issue of *The DO* magazine focused on the profession's efforts in coding and reimbursement and listed the Academy as a source of several resources developed by the OMEC.

1) *Osteopathic Medicine: A Description of Principles, Practice and Coding* - a 10-minute video suitable for educating policy makers on the uniqueness of physicians who utilize OMM in their practices.

2) *Osteopathic Medicine: A Cost-Efficient Approach to Medical Care* - a brochure developed for employers, the insurance industry

and managed care entities to demonstrate the cost-effectiveness of osteopathic medicine.

3) *OMM Coding Packet* - an updated, more comprehensive version approved by the Board of Trustees in October 1995 to assist AAO members with coding practices in their offices.

4) *Osteopathic Medicine: A Distinctive Branch of Mainstream Medical Care* - a brochure for patients as well as policy makers which outlines basic osteopathic principles and their application in the current practice of osteopathic medicine.

The OMEC continues to address important medical economics issues with the addition of "The OMM Coding Corner" in *The AAO Newsletter*, preparation of position statements for consideration by the AAO's Boards of Trustees and Governors, and monitoring of the Bureau of Experts. The OMEC also has scheduled a "Train the Trainers" workshop at the 1996 Convocation to prepare interested Academy members to work with their state osteopathic associations in advocacy for appropriate OMT reimbursement by third-party payors.

Is there significant work yet to be done? The answer is a resounding YES! However, AAO members should be proud that the Academy leadership is intimately involved in the profession's work groups which are addressing physician payment issues nationally. AAO President **Boyd Buser** has succeeded the pioneering **Herbert Yates** as OMM advisor to AMA's Relative Value Updating Committee (RUC). The RUC is charged with assigning work values to CPT codes. In his advisor's role, Dr. Buser provides valuable counsel to **David F. Hitzeman**, the osteopathic profession's sole representative on the RUC.

Dr. Yates is Vice Chairman of the AOA Coding/Reimbursement Advisory Panel and **Judith O'Connell** is the Academy's representative. The panel provides consultation to the AOA's Division of Payor Relations and the Board of Trustees on physician payment policy issues. Major concerns of the panel are the preservation of separate OMT codes in the *CPT Manual* and reimbursement for OMT in addition to evaluation and management services.

The Academy's Louisa Burns Osteopathic Research Committee (LBORC) is addressing the organization's goals to document the efficacy of osteopathic manipulative treatment. Under the leadership of Chairperson **Sandra Sleszynski**, the Committee will conduct a pilot research study on the utilization of a standardized record form. The Committee has also recommended the development of a computerized model to record the physician-patient encounter, a model which will provide for quick and easy retrieval of data for outcomes research projects. The Academy's objective is to publish the results of ten outcome studies on OMM by July 2000. The Education Committee also accepted the LBORC's recommendation for a research workshop at the annual Convocation, a plan to facilitate participation by AAO members in OMM research projects.

In summary, I believe that the Academy's leadership is proceeding with a reasoned, comprehensive plan to advocate for appropriate reimbursement for OMM by third-party payors. The AAO's efforts are not isolated, but rather in collaboration with its parent organization to ensure consistency and the widest representation of the profession. This strategy should result in policies and procedures which will engender greater participation by all osteopathic physicians who utilize OMT in their practices. □

AAO Calendar of Events

March

26-30

Annual Convocation

American Academy of Osteopathy
Stouffer Waverly Renaissance Hotel
Atlanta, GA

31 hours of Category 1-A Credit

Contact: Diana Finley
(317) 879-1881

May

17-19

Muscle Energy Tutorial

20 Hours; Category 1A

Walter Ehrenfeuchter, DO, FAAO,
Program Chairperson;

Adams Mark Hotel, Indianapolis, IN

Contact: Diana Finley
(317) 879-1881

18-19

Advanced Percussion Vibrator

Robert Fulford, DO & Richard Koss, DO

15 Hours, Category 1A

Adams Mark Hotel, Indianapolis, IN

Contact: Diana Finley
(317) 879-1881

June

28-30

Osteopathic Considerations

in Systemic Dysfunction

25 Hours, Category 1A CME

Michael Kuchera, DO, FAAO,

Instructor and Program Chairperson

Chicago College of Osteopathic Medicine

Contact: Diana Finley
(317) 879-1881

July

26-30

Intermediate/Advanced Visceral

Jean- Pierre Barral, DO, MROF

John Glover, DO, Program Chairperson

40 Hours, Category 1A CME

Loews Ventana Canyon, Tucson, AZ

Contact: Diana Finley
(317) 879-1881

27-28

Concept and Technique

of the Levitor Orthotic Device

Michael Kuchera, DO, FAAO,

Instructor and Program Chairperson

16 Hours, Category 1A CME

Loews Ventana Canyon, Tucson, AZ

Contact: Diana Finley
(317) 879-1881

September

26-29

AAO Fall OMT Update

Application of Osteopathic Concepts

in Clinical Medicine plus

Preparation of the OMM Boards

Ann Habenicht, DO, Program Chairperson

22 Hours, Category 1A

Grand Floridian Hotel, Orlando, FL

Contact: Diana Finley
(317) 879-1881

27-29

Introductory to Visceral Manipulation

John Glover, DO, Program Chairperson

25 Hours, Category 1A

Holiday Inn North

Indianapolis, IN

Contact: Diana Finley
(317) 879-1881

October

7-10

AOA/AAO Convention:

OMT in a Busy Family Practice

Same CME as AOA

John Hohner, DO, Program Chairperson

Las Vegas Hilton

Las Vegas, NV

Contact: Diana Finley
(317) 879-1881

25-27

Myofascial Release

20 Hours, Category 1-A

Judith O'Connell, DO, FAAO, Prog. Chair

Texas College of Osteopathic Medicine

Fort Worth, Texas 76107

Contact: Diana Finley
(317) 879-1881

25-27

Counterstrain

20 Hours, Category 1-A

Mark Cantieri, DO, Program Chairperson

Texas College of Osteopathic Medicine

Fort Worth, Texas 76107

Contact: Diana Finley
(317) 879-1881

26-27

Facilitated Positional Release

12 Hours, Category 1-A

Eileen DiGiovanna, DO, FAAO,

Program Chairperson

Texas College of Osteopathic Medicine

Fort Worth, Texas 76107

Contact: Diana Finley
(317) 879-1881

November

15-17

A Functional Orientation for Technique

20 Hours, Category 1-A

William Johnston, DO, FAAO and

Harry Friedman, DO

Hotel TBA

Indianapolis, IN

Contact: Diana Finley
(317) 879-1881

16-17

Basic Percussion Vibrator

(Fulford's Method)

15 Hours, Category 1-A

Robert Fulford, DO and Richard Koss, DO

Hotel TBA

Indianapolis, IN

Contact: Diana Finley
(317) 879-1881

January 1997

12-19

Cruise/CME

San Juan, Puerto Rico and then

Sail the Southern Caribbean

20 Hours, Category 1-A

Contact: Diana Finley
(317) 879-1881

Mind, machinery, and manipulation

by Melicien A. Tettambel, DO, FAAO

Editor's Note: *Melicien Tettambel, DO, FAAO is a 1978 KCOM graduate and currently is certified in obstetrics and gynecology and OMM. Dr. Tettambel is a member of the AAO's Board of Trustees, Board of Governors, Educational Standards & Evaluation Committee, Education Committee and the American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine. In addition to the AAO, she holds membership in AOA, ACOOG, The Cranial Academy, American Association of Gynecologic Endoscopists, St. Louis Gynecologic Society and Illinois Association of Osteopathic Physicians and Surgeons.*

Dr. Tettambel was selected by the AAO because of her commitment to osteopathy and her ability to teach on the original basic techniques of Andrew Taylor Still. The following is her 1995 Scott Memorial Lecture.

I wish to express my deepest gratitude to the American Academy of Osteopathy and to the Kirksville College of Osteopathic Medicine for having the honor to present the Scott Memorial Lecture on Founder's Day, 1995. I am also humbled to be standing before an assembly of osteopathic luminaries, some who have also delivered a Scott Memorial lecture, some who have attempted to advance my skill and knowledge in osteopathic medicine (before and after graduation from KCOM), and some who continue to accompany me in my process of education.

The assignment of this Scott Memorial lecturer is to illustrate contemporary interpretation of the philosophy and

technique of our founder, Dr. Andrew Taylor Still. Investigation of previous topics included two lectures filled with inspiration and challenges to students of osteopathy: 1972 – "The Law of Mind, Matter and Manipulation." I have accepted the task to continue to exhort

***By building, repairing
and operating
machinery, he (Dr. Still)
came to see the
human machine
as an integrated unit
of motor, framework,
and other equipment,
related by blood and
nerve supply, bones,
muscles and ligaments.***

students of osteopathy to examine and adopt those principles developed by our founder through yet another discourse weighted heavily with marvelous "M" words: mind, machinery, manipulation!

Osteopathy, the law of mind, matter, motion was first promoted in a Missouri town of mud and mules by a manipulator who developed extraordinary palpatory skills from his dedication to the study of anatomy. Dr. Still insisted that our sophisticated palpatory clinical skills would be the reward for many hours spent in the dissection laboratory, studying the human body in such detail so as to appreciate structure and function by touch. From our discriminating tactile

clinical experiences, we could even evaluate and interact with human anatomy and physiology in a way that exceeds the bounds of length, height, and depth.

Medical technology has recently been of assistance to the non-osteopathic medical community in the attempt to illustrate a palpatory experience by the use of computers and eyepiece goggles to create a synthetic environment, a developing concept known as "virtual reality." However, I should like to explore with you the kinds of information obtained from osteopathic palpation that cannot be quite matched nor replaced by medical technology.

I shall also heed Dr. Still's advice, "We must remember that when we write or talk, we have asked the listener to stop all pursuits to read our story or to listen to it. We must be kind enough to give him something in exchange for his precious time. We must remember that time to an American is too valuable to be given for hours to a long story that does not benefit him."

In the 1860s, Dr. Still reportedly took a course of instruction in the Kansas City School of Physicians and Surgeons, studying medicine as it existed in America at that time. In a 1908 *Ladies Home Journal* interview, he stated, "I took up the regular practice of an allopathic physician. I was called a good doctor," But, that was not all. Prior to this formal training, Dr. Still had acquired other M-word training which led him to develop principles of osteopathic manipulation. These experiences were those of the ministry (through his father, and through his personal relationship with God and nature); and, interest in

→

machinery (millwork as well as mankind). By building, repairing and operating machinery, he came to see the human machine as an integrated unit of motor, framework, and other equipment, related by blood and nerve supply, bones, muscles and ligaments. In order to become a successful mechanic, he developed those palpatory skills that today surpass the concept of "virtual reality." He taught us to "see" with our hands what computers cannot touch.

"Virtual reality," like osteopathy, has not yet been totally defined, only described. A current attempt is "a simple term for a synthetic environment in which the positions and movements of the observer determine the scene that is seen, heard, or touched. Because the synthetic environment can be composed by creating an arbitrary three-dimensional space, it is a virtual world." Necessary machinery required to interact with a virtual scene consists of special goggles in which each eyepiece is replaced by a small video screen, and a computer that recalculates and redraws 3-dimensional images that each eye sees. Thus, the observer has the sensation of being inside the scene itself and of occupying a place in it. For the scene and the computer, any three-dimensional set of data can be used to make a surface. If this surface has a recognizable shape, there are functional relationships that link the two independent variable (z axis).

In medical education, a considerable amount of money and time has been spent on technology that only simulates patients and anatomy, and becomes outdated all too soon! Why not spend that time and money on our hands, which with good care, will not require replacement parts; although our brains may need some updating and reprogramming about what is thought regarding the information that has been collected through our fingertips?

Dr. Still started his study of mankind through dissection of muscles, nerves, veins, and bones. He would take a bone into his hands and stand blindfolded to

"feel" it, so that he could identify it, and then designate its exact location within the body. He used his hands to familiarize himself with the working and nonworking parts of his patient/machinery. He became acquainted with the framework and its organization on an X or Y axis. We continue to do the same. When performing our structural exams, we assess our patients in either sitting, standing, or reclining positions. We may record spinal segmental motion within the dimensions of flexion, extension, side-bending, and rotation, with respect to a proximal segment.

*He (Dr. Still)
taught us
to "see"
with our hands
what computers
cannot touch.*

After utilizing his hands to become introduced to structure, Dr. Still used them to evaluate function. Knowledge of muscles, ligaments, tissues, arteries, veins, lymphatics, and nerves in a dynamic machine, caused him to palpate strength, rhythm or pulsation, and direction of motion not appreciated in cadavers. Palpation is no longer static. Dr. Still taught us to assess not only spatial relationships of the musculoskeletal container to its glandular or organ contents. Moving from X and Y axes to the incorporation of the Z axis into our three dimensional "scene" or anatomic model, but, also, to appreciate qualities and ranges of motion within the structures that are palpated within the space between our hands. With our hands we appreciate degrees of flexion, extension, intensity of pulse rate, spasticity of muscles, fluctuation of the cerebrospinal fluid. Data have been collected that steer our brains to processing information which in turn,

guide us to select further treatment plans that may consist of surgery, pharmacology, exercise, or further osteopathic treatment. It is our tactile reassessment that will also further assist us in any necessary modification of our treatment plans.

Palpation also contains other dimensions; one is time. Closely related is awareness of hot and cold to evaluate spinal areas. Perceptible changes in temperature not only give us clues about acuteness or chronicity of an ailment, but also give us clues about the ability of the nerve or blood supply to function within an altered container. A cold extremity in a diabetic or stroke patient provides the palpator some diagnostic and prognostic indicators which give one a sense of a timeline in progression of the pathology, as well as a sense of a timeline to address the pathology.

Tissue texture, to the educated hands, provides appreciation of the aging process influenced by stress (mechanical as well as metabolic) on the machinery of life. Palpation of lumps and bumps may denote benign or malignant conditions that may or may not be reversible when attempting to repair the equipment. Chronologic age may not match physiologic age when joint crepitus manifests itself during a knee examination on a 20-year-old athlete.

History in the study of mankind marches forward when the obstetrician has announced that the cervix is now 10 centimeters dilated. Hopefully, the baby will appear shortly thereafter! When the mother has been osteopathically treated and her body has responded to our manipulations, she will be prepared to repeat the childbirth experience (maybe!). As for her infant, an osteopathic palpatory examination may identify and address structural dysfunctions that might have impeded a healthy and happy growth and development during childhood. By using our hands, we can also touch the future!

Osteopathy, especially the refinement of palpation, will continue to surpass developing scientific concepts, such as

virtual reality. Technology can aid the human brain to analyze and interpret complex scenes, but it is our senses, (palpation and inspection in this instance) that assemble data for multidimensional processing, whether it be by our brains or computers, that our brains continue to develop. Our hands and brains are capable of reintegrating and reevaluating data to interact with human physiology, not merely to observe it.

Another dimension of palpation exists that is difficult to define, but common to experience, is that of spirituality. How many times have you wondered, "how many treatments will it take for the patient to respond or to exhibit his potential for health?" How many instances occurred after a treatment when the patient did not look any differently than he or she did the last time in your office? Yet, today you perceived a greater ability to palpate your patient and appreciate him or her from a different sensory perspective – from boney to membranous, from membranous to fluid, or from fluid to vibration or any other sense of energy associated with "essence" or existence. And it was also today, your patient reported a sense of relief, well-being, energy, or any other term describing more than a physical alteration, as a direct result of your palpatory efforts.

Finally, palpation stimulates our minds to explore clinical situations that help us to address the unfamiliar after we have studied the familiar in our daily practice, so that perhaps we may come a little closer to knowing ourselves. What is our limit, if we have any? How can we conquer the unknown? At this point in time, we have our minds and our hands, as well as machines that can collect, compute, assemble, and reassemble data within a synthetic environment over when we continue to maintain some control. However, when we have a foreign palpatory encounter, perhaps we need to place our skill and knowledge into bigger hands for assistance. Dr. Still recognize that at times, "I began to feel that I was irresistibly headed for some road. What road? I, myself, know not.

We must blend ourselves with and travel in harmony with nature's truths."

Having highlighted the strengths of osteopathic palpation that are attempted to become illustrated or even duplicated by modern medical technology, I should like to propose this challenge to the osteopathic profession; continue to explore, expand; and share our study of osteopathic palpation. This information can only be transferred from teacher to student, not copied from books or computer programs. As we hand down our experiences, recognize that we must not only cultivate students, but also teachers must show that osteopathy continues to flourish. Dr. Still, our mentor, identified the need to learn as well as to teach when he stated: "I worked alone, studying, investigating, experimenting. Gradually, people began coming to me in increasing numbers and soon I found that my practice was beginning to grow beyond the limits of my strength. I concluded to teach others the principles that underlay my work. I realized that I must have help or break down." Let us continue to study the anatomy between our hands and to interact with human structures in an environment that is never synthetic, static, or limited to only three dimensions. Do not let technology surpass what it is supposed to supplement as a learning aid in the tactile experience of dynamic anatomy and physiology!

In closing, I should like to propose a secondary challenge to a future Scott Memorial lecturer. How about a continuation and maximization of the meritorious "M" word series for the audience to mull over? Thank you.

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*"My work
for over thirty years
has been confined
to the study of man
as a machine
designed and produced
by the mind
of the Architect
of the Universe.*

*I hope I have
by my study
discovered and been able
to give to the world some
of the Truths of Life
and the laws that operate
to keep the body
in a healthy condition."*

A.T. Still



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Program

Friday, May 17 (8:00 am - 5:00 pm)

- Hour 1: History of and Physiologic Basis for Muscle Energy Technique
- Hour 2: Diagnosis of Hip Girdle Dysfunction
- Hour 3: Treatment of Hip Girdle Dysfunction
- Hour 4: Diagnosis of Innominate Dysfunction
- Hour 5: Treatment of Innominate Dysfunction
- Hour 6: Diagnosis of Pubic Symphysis Dysfunction
- Hour 7: Treatment of Pubic Symphysis Dysfunction
- Hour 8: Diagnosis of Sacral Dysfunction

Saturday, May 18 (8:00 am - 5:00 pm)

- Hour 9: Treatment of Sacral Dysfunction
- Hour 10: Diagnosis of Lumbar Dysfunction
- Hour 11: Treatment of Lumbar Dysfunction
- Hour 12: Diagnosis of Thoracic Dysfunction
- Hour 13: Treatment of Thoracic Dysfunction
- Hour 14: Diagnosis of Costal Dysfunction
- Hour 15: Treatment of Costal Dysfunction
- Hour 16: Diagnosis of Cervical Dysfunction

Sunday, May 19 (8:00 am - 12:00 noon)

- Hour 17: Treatment of Cervical Dysfunction
- Hour 18: Diagnosis and Treatment of Shoulder Girdle Dysfunction
- Hour 19: Diagnosis & Treatment of TMJ Dysfunction
- Hour 20: Muscle Energy's Place in the Grand Scheme of Things

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A functional approach to heel lift therapy

by Kenneth H. Johnson, DO

Editor's Note: Kenneth H. Johnson received his DO degree from the University of New England College of Osteopathic Medicine in 1992. While a student, he served as national representative, vice chairman and chairman of the UAAO as well as on the SOMA Osteopathic Advisory Board and the AAO's Undergraduate Academies Committee. Dr. Johnson is currently on faculty in the OMM Department at UNECOM.

Heel lift therapy has been used to address leg length inequality (LLI), postural decompensation in the coronal plane and various complaints of pain. Much has been written in osteopathic literature regarding the use of heel lift therapy, with specific instructions for the implementation and continued use of lift therapy.¹

One of the prime dictums in osteopathic philosophy is that structure and function are intimately related. Most of the literature describes using heel lift therapy to normalize structure without taking into consideration function. For example, if someone has a 1/2 inch leg length discrepancy with a sacral base declination and the compensatory lumbar scoliosis, treatment may be initiated at some percentage of this 1/2 inch with progression up to the full 1/2 inch. (The goal being normalization of the sacral base declination and the compensatory lumbar scoliosis.) This approach fails to take into consideration improving the function of the sacrum, innominates and lumbar spine. Heel lift therapy has very much been an anatomic approach to treatment.

In reviewing the literature on leg length inequality as related to back pain, some authors state that there is a questionable association of LLI with back pain,² while others state the association is clear. In an analysis of the radiologic literature, it was shown that there is a statistically higher prevalence of LLI in patients with LBP (6339 patients) than asymptomatic controls (647 patients).³ However, there is not an increase in the incidence of LBP in patients with LLI. Lift therapy has been shown to be beneficial in patients with LLI related to LBP^{4,5} and the obstetrical patient with LBP/flank pain and LLI.⁶

It is the intent of this article to describe a functional approach to the diagnosis of LLI and its effect on posture and,

subsequently, to describe a functional approach to heel lift therapy. The details of radiographic analysis have been discussed elsewhere and will be only briefly mentioned here.

Posture is a complex interaction of gravity's effects on the body and the body's attempt to compensate for this. Various neurologic mechanisms, including input from the eyes, the vestibular apparatus, and neck as well as proprioceptors in muscle and joint receptors, combine to attain a given posture. Emotion can also have a powerful effect on posture. Using a functional model of treatment takes into account the dynamic responses of the body. The physician is able to get immediate feedback on the efficacy of treatment in an objective manner.

Discussion

Diagnosis

Much osteopathic diagnosis and treatment has been described in the supine position, but we spend most of our time in the upright position. Therefore, it makes sense to obtain diagnostic information in the upright position.

Landmarks for Coronal Plane Decompensation & Leg Length Inequality

1. A. C. Joints
2. Inferior angles of scapulae
3. Iliac crests
4. Greater trochanters
5. Popliteal folds
6. Arches

Table 1 – Standing Exam

With the patient standing and the examiner behind the patient, a number of landmarks are compared (**Table 1**). The patient is asked to stand with his/her feet pointing forward and separated as they would normally stand and the heels are placed in line with each other (**Fig. 1**). Asymmetry of the position of the head in relation to the neck is checked; as well as intrinsic cranial asymmetry. (**Fig. 1**). The examiner places hands on top of the AC joints to compare their heights (**Fig. 2**). The inferior angles of the scapulae are palpated and any

→



Fig. 1 – Assessment of LLI and postural decompensation.



Fig. 3 – Assessment of inferior angle of scapulae



Fig. 4 – Flank skin fold asymmetry



Fig. 2 – Examination of AC lgt. jt. height.



Fig. 5 – Assessment of iliac crest heights

difference noted (side to side as well as comparing their relationship to the AC joints) (Fig. 3). It may be found that the right AC joint will be superior compared to the left, but this may not be as noticeable at the inferior angles of the scapular due to shoulder girdle rotation.

Flank skin fold differences are examined (Fig. 4). The iliac crests are palpated from behind with the examiner's eyes at crest height level (Fig. 5). Difference of <math>< 5\text{mm}</math>. (1/2 inch) in sacral base declination may make the iliac crests poor predictors

of the direction or degree of sacral base unleveling.^{7,8} Therefore, one takes all measurements into account to make the diagnosis of LLI or postural decompensation.

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The examiner places his thumbs in the sacral sulci with fingers on the iliac crest. In this position, primary and secondary respiration are assessed (Fig. 6). Palpation for the cranial rhythmic impulse in the standing position is done (a technique not often discussed in cranial courses). Assessment of the secondary respiration of the sacrum is noted. If little motion is palpated, ask the patient to take in slow/deep breaths, to note amount of the motion of the sacrum.



Fig. 6 – Assessment of primary and secondary respiratory motion of sacrum and innominates.

When the examiner is assessing primary and secondary respiratory motion, the base of the sacrum (at the lumbosacral junction) should move posteriorly during inhalation in both primary and secondary respiration and the lumbar curve will decrease. This motion can be augmented by having the patient take in a deep breath. As the sacrum moves posteriorly, the innominates flare out. In exhalation, the reverse of each of these occurs.

The physician then performs the standing flexion test and notes which side is positive. (See Flexion Tests and Interpretation.)⁹ The examiner palpates the greater trochanters comparing their heights (Fig. 7). The creases of the popliteal fossas are compared (Fig 8). The arches are palpated by sliding the examining fingers under each foot, checking for flatness of the arch on one side or the other (Fig 9).

The goal of the screening exam is to determine:

1. leg length inequality
2. postural compensation
3. postural decompensation

It is only through the integration of all this information that one can make clinical decisions about LLI and postural compensation/decompensation.



Fig. 7 – Assessment of greater trochanters heights



Fig. 8 – Assessment of poplited creases



Fig. 9 – Assessment of arches

continued on page 26

Sacral shear: Review and a new treatment method for obstetrical patients

by Robert C. Treadwell, UTF and Warren W. Magnus, UTF
University of North Texas Health Science Center
Texas College of Osteopathic Medicine

Introduction

Sacral shear is a common diagnosis in the general population and is associated with back pain that is often unresponsive to other treatments, including lumbar spinal manipulation. The obstetrical patient suffers from particular susceptibility to this phenomenon and poses unique treatment difficulties for the osteopathic physician in clinical practice.

Sacral Shear (Definition)

According to Kuchera, "a sacral shear is a nonphysiologic motion of a sacroiliac joint produced by opposite forces, one superior and the other inferior, at the sacroiliac articulation."¹ The superior force occurs through the innominate from the ischial tuberosity or from the hip articulation at the acetabulum. The inferior is the weight of the trunk delivered through the spine at the SI joint (Fig. 1).

These forces can be brought the bear on the SI joint through a variety of means, but is generally traumatic in origin. Often the patient history will include a fall on the gluteal area, a surprise step off of a curb or into a hole, or other trauma that would induce unilateral forces at the SI joint. This is a similar phenomenon to that which creates the superior innominate shear, but the force vectors are localized to the SI as opposed to distributed upwards through the innominate.

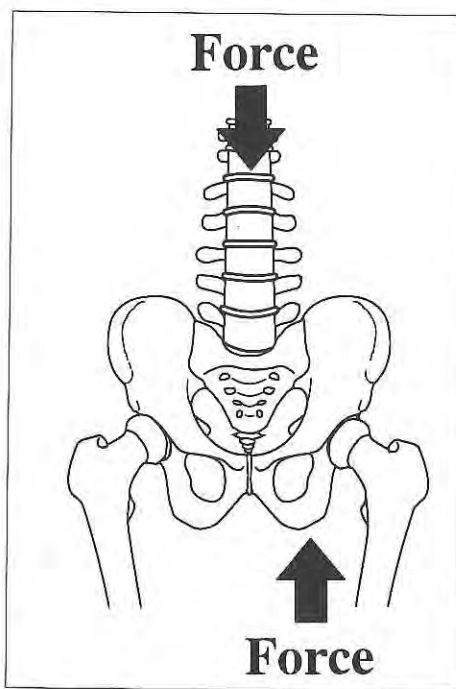


Fig. 1

Symptomatology can vary from unilateral SI joint pain, often described by the patient as "hip pain," to diffuse pain resulting from the sacral unleveling that the shear creates.

Sacral Shear (Findings)

Sacral shearing creates unique findings that are often dramatic. Innominate motion may be reduced bilaterally and pelvic compression testing may be equivocal.

Palpation of the inferior lateral angles (ILAs) of the sacrum often reveals a markedly inferior ILA on the side of the shear. Static findings are the diagnostic keys. The inferior ILA on the side of the shear is usually posterior and the sacral base is usually anterior on the side of the shear creating a deep sacral sulcus² (Fig. 2). Even in cases of marginal ILA

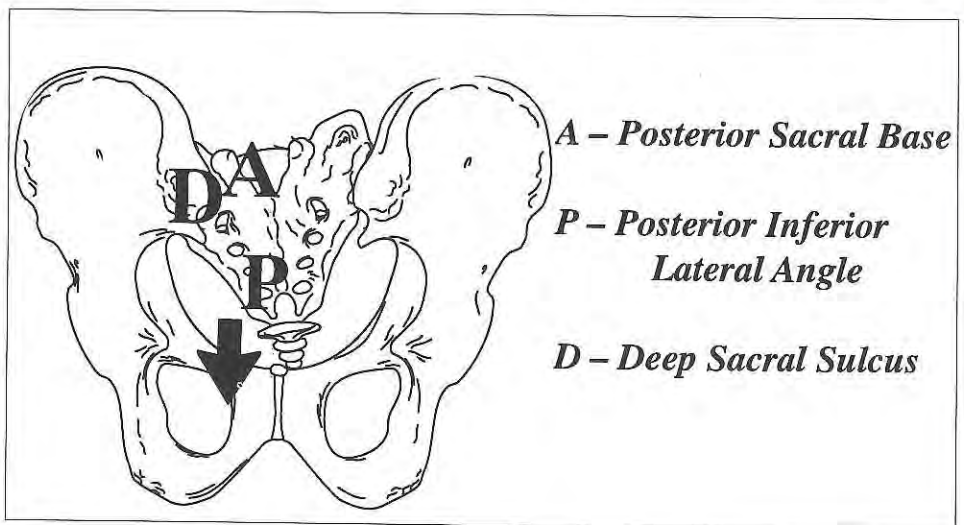


Fig. 2

inferiority, the motion testing of the sacrum will show significantly reduced motion at all poles.

Sacral shears are identified based on the involved side, the side of the inferior ILA. Thus, a low ILA on the left would be identified as a left sacral shear. Kimberly further identifies the shear as unilateral, so the left shear becomes a "left unilateral sacral shear."

Obstetrical considerations

The obstetrical patient has unique considerations that both make the patient more prone to sacral shearing as well as complicating treatment. As pregnancy progresses, ligaments throughout the body, but particularly in the pelvis become lax in preparation for parturition.³ This phenomenon results in an environment in which a sacral shear can occur with relatively mild trauma, such that the patient's history often does not reveal the source of the sacral shear.

A dysfunctional sacrum subsequently places undue strain on the ligaments of the pelvis and surrounding musculature leading to multiple complications. These include low back pain and pelvic pain. The tightening of the pelvic muscles that results can restrict fluid drainage from the lower limb through the pelvic diaphragm resulting in edema and venous insufficiency.

Treatment of the sacral shear

Kuchera and Kimberly both describe multiple techniques for the treatment of sacral shear, but all of their described techniques are difficult if not impossible to perform in the third trimester. Prone techniques are complicated by the presence of the gravid uterus, making patient comfort as well as uterine compression concerns. Supine techniques may also be complicated by compression of the abdominal vasculature by a particularly large gravid uterus.

A lateral recumbent technique is detailed by Kuchera. Unfortunately, this



Fig. 3

method requires one operator to stabilize the ILA on the sheared side and another operator to provide a high velocity-low amplitude tug to the patient's leg on the sheared side to reduce the sacral shear. This tug technique may cause a strain of the knee ligaments which are already loose secondary to relaxin in the obstetrical patient.

A new technique

To treat a sacral shear in a lateral recumbent position, the patient is

positioned with the sheared side up. Both legs are flexed to provide stability to the patient and promote patient comfort. The operator is seated behind and facing the patient on a stool. The operator utilizes their caudal hand to raise the patient's leg on the side of the shear and then stabilizes the leg by placing their elbow on the table (Fig. 3). The operator then places their cephalad hand on the sheared ILA, contacting it interiorly (Fig. 4). The patient is asked to press downward against the operator's



Fig. 4

hand with the raised leg. As the SI joint gaps from the muscular force, the operator provides a springing force cephalad through the inferior ILA. This procedure can be repeated as needed to reduce the sacral shear.

Follow-up

Sacral shears with successful treatment rarely recur. The most common cause of recurrent sacral shears is a long-standing shear, which has stretched the supporting ligaments.

Pregnant patients with unusual ligamentous laxity may repeatedly shear their sacra and require repeated treatment throughout the pregnancy. Patients should be reexamined a week following initial treatment of a sacral shear to verify both treatment success and to evaluate pelvic stability.

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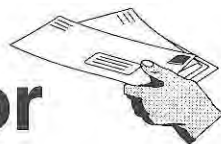
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Letter to the Editor



Dear Sir,

I am writing to commend the American Academy of Osteopathy for co-sponsoring the recent Second Interdisciplinary World Congress on Low Back Pain held in San Diego.

As osteopathic physicians, the diagnosis and treatment of low back pain, specifically involving the lumbar spine and sacroiliac joints, are our "bread and butter." The osteopathic profession has been at the forefront of diagnosis and treatment for somatic dysfunction of these areas, but there is significant research, outside the osteopathic profession, both in the basic sciences and clinical management of disorders of the sacroiliac joint.

There is no dispute that the treatment of low back pain, particularly involving manual techniques, requires significant art as well as science. Research is only now documenting motion and dysfunction involving the sacroiliac joints, which we as clinicians have known for a long time. Scientific study may, however, provide additional understanding of this system different than the interpretation arrived by clinicians practicing the art of manual

medicine. For that reason, I do feel that it is important for the osteopathic profession to continue supporting research, not only to validate manipulative treatment, but also to continue to lead to better understanding of the scientific basis for manual medicine.

I think that we in the osteopathic profession sometimes overlook the contributions to manual medicine by other physicians, both in this country and abroad. I personally was impressed to see the AAO President-elect, Dr. Kuchera, on the program with other renowned researchers including Drs. Vleeming, Mooney, Gracovetsky, among others. It is very healthy for osteopathic researchers to communicate with other researchers who may approach the lumbar and sacroiliac regions from a surgical or medical standpoint. Our interpretation of the data may differ, but that will lead to better understanding and development of both the science and art of manual medicine in the future.

Sincerely,
Charles H. Cummings, DO

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in addition to the above list,
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National Osteopathic Foundation offers scholarships and programs that benefit osteopathic medical students

Everyone needs a support system. Perhaps no one needs it more than a medical student. But, if you happen to be a medical student in the field of osteopathic medicine, you are fortunate to have access to a very special resource available only to osteopathic medical professionals—the National Osteopathic Foundation (NOF).

For 46 years, NOF has worked arm-in-arm with the American Osteopathic Association to foster the study of osteopathic medicine and advance and raise awareness of the profession through scholarships, student loans, and research grants. This investment in the future amounts to a total of \$90,000 awarded annually to osteopathic medical students and physicians through 22 different NOF-supported programs.

In addition, NOF has partnered with the American Academy of Osteopathy (AAO) to support the Visiting Clinicians Program, which allows practicing osteopathic physicians to give presentations to first- and second-year students at osteopathic colleges nationwide. The program, funded by a \$25,000 grant by NOF, is beneficial to students because it brings practical experience in the classroom. As described by the AAO, "This program involves competent and skilled Academy members who visit, instruct, demonstrate, and lecture students on their clinical knowledge and skills of osteopathic principles and practice."



Following is a summary of other NOF programs specifically designed to assist osteopathic medical students:

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The Zeneca Pharmaceuticals Underserved Healthcare Grant

—awards \$5,000 to one or two junior medical students who demonstrate a commitment to practicing in underserved and minority populations.

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—provides financial assistance through loans to qualified third- and fourth-year osteopathic medical students.

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—NOF's best known program, the Osteopathic Seal Program has raised \$1 million over the last 10 years, providing the financial backbone for numerous student loans and research grants. Seals are distributed annually to osteopathic physicians, hospitals, and colleges who in turn make donations to NOF for the privilege of using the seals on their business and personal correspondence.

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None of your business

By: Alan R. Becker, DO, FAAO

It was cold that morning in Kentucky in 1939. A winter rain followed by a sudden drop below freezing had left most of the ground covered with a sheet of ice and a light blanket of snow.

"Doc, this is Lyman. You'd better come out to the house."

"What's wrong Lyman?"

"It's Maw. She done fell and hurt herself."

"I'll be right over."

As I hurriedly threw on my clothes, grabbed my professional bag and went out to the car, I mentally reviewed what I knew of "Maw" Hale. She had been one of my first patients when I had started practice in a small Kentucky town. (I had just taken the board and received my license the month before.) Her son, whom I had treated, had asked me to look her over.

She was sitting in a rocker when I first saw her, a wizened bit of a woman with arthritically twisted hands and knees. As I questioned her and examined her it seemed apparent that this little old lady was maintaining her physical body by sheer determination in spite of its manifestly failing functions. She didn't complain about the shortness of breath or the swollen ankles which slowed her down as she tried to keep the house neat, so that the rest of the family could do their jobs on the farm. The pain in her arthritic hands and back was simply something to be borne quietly and patiently.

"Don't you bother about me, Doc. There's lots more that need you more than I do" was her often repeated comment, as I came by to give her some measure of relief and some slight boost toward greater well-being and comfort. We both knew that there was not much to be done to repair the ravages of age,

hard work, and malnutrition. She was grateful for the little improvement that enabled her to do a little more. Maw had borne seven children and lived with Lyman, the eldest, and his wife and family of four.

All this and more drifted through my mind as I cautiously eased the car out of town on the Muddy Creek Pike. Lyman had been normally raciturn when he called so I had a little to go on as to what I would find when I reached the house. Finally, I reached the narrow lane of lightly frozen mud leading to a steeply

*"Nothing can be done,
she's too far gone,
it's too late,
what can I tell the family,
what can I do,
gotta look like
I'm doing something,
but what. . .*

slanted rock-strewn drive running for fifty yards twistingly up to a point near the barn about thirty feet below the house. A set of wooden steps lead to the front door.

I knew that my car would never negotiate the frozen lane and drive, and I was even dubious whether I could get back on the Pike if I started up the hill. How could an injured old lady be transported down the hill and into the hospital? No, I thought, whatever had happened to "Maw" would have to be handled at home. I was young in practice and woefully inexperienced in clinical judgement, but I was the one on call.

Finally I crept up to the house and walked in.

"She's in there, Doc." said Lyman's wife, pointing to the bedroom, I walked

in and there was Maw, lying in bed, covered with blankets, unconscious and breathing stertorously and shallowly.

"What happened?" I asked Mrs. Hale, as I felt for the thready pulse.

"We don't rightly know, Doc. Lyman found her out back near the outhouse just a little while before he called you. She must have gone out there sometime during the night and slipped and fell. Don't know how long she'd been out there, but she was awful cold and blue."

"Didn't you hear her go out?"

"Maw. She goes out there two or three times a night, usually once before midnight and sometimes once or twice later. We went to bed about ten o'clock 'cause it was gettin' pretty cold and Lyman wanted to save on the coal. Guess she might of been out there four-five hours, she was that blue and cold. We thought she was dead at first but then we seen that she was breathing, so Lyman brought her in here and went to call you, while I covered her and built up the fire."

I went on with my exam in silence. Pneumonia, congestive heart failure, three broken ribs. I sat back appalled, then turned to Lyman who had just come in from the barn. "If your brothers and sisters want to see Maw alive you'd better call them to get over here. I don't think she can last out the day."

As I think back, I can see the scene: a young doctor, green as grass, less than a year out of his internship, sitting beside the bed of an unconscious, probably dying old lady in a small bedroom of single-wall construction heated by a cannal of coal fireplace on the far wall. And as clear as the picture comes the train of thought that ran through my mind, "Nothing can be done, she's too far gone, it's too late, what can I tell the family, what can I do, gotta look like I'm doing something, but what?—give her

heart stimulant—but what—what good would it do—her whole system is failing and shutting down.”

And as I sat there trying to justify my inadequacy to meet the problem, I suddenly recalled a fellow student asking a teacher, “Doctor, how can you tell that this patient has gone too far, that he or she is beyond help?”, and the sharp answer, “None of your d— business!, take off your coat and go to work!”

I looked down at Maw and thought “she had faith in me, try to justify it!” I took off my coat and went to work, gently raising the ribs to ease the congestion, aligning the fractured ones as well as I could by touch. I didn’t dare to strap the chest as I knew the labored lungs needed all the space they could get. I knew the fractured ribs would heal if Maw survived. Stimulants were given gingerly to support the laboring heart and heat was applied to warm the still chilled body. A window was opened slightly as the fireplace was vitiating the air of the room and using all the sorely needed oxygen. At that point I was too inexperienced to even think of ordering a tank of oxygen, or even how I could get it. All I had was my knowledge, book-learning though it was, my hospital and clinical training, some experience in caring for some seriously ill patients, my hands and knowledge of osteopathy, and a few medicines of doubtful value. But beyond all this I knew that Maw Hale was still alive and fighting to keep that frail, half-frozen body going, and she had faith in her God and in me.

All day long, I sat at the bed side, giving gentle stimulation to the respiratory and circulatory centers every few minutes, gently raising the ribs and warming the body by passive motion. By noon, I could detect some change for the better, and by evening when the family had gathered, Maw was conscious

and able to recognize them.

“I thought you’d be here, Doc. Don’t worry none about me,” she whispered, “I’ll be all right.”

I claim no credit for the survival of that worn-out body. Had it not been for Maw Hale’s determination to live because she still had a job to do, nothing in medical science could have made one iota of a difference. Remember that this was 1939 and there were no antibiotics or “miracle drugs,” even if they had been available they would have offered nothing in this situation. But the physiological forces of nature and the will to live were enough to turn the tide. I firmly believe, however, that if I hadn’t recalled the teacher’s admonition and dismissed all judgment as to whether it was possible for Maw Hale to live, if I had not “just got to work and let the Lord do the worrying,” as Maw would often say, the outcome would have been different.

There is little more to say save that when I left Kentucky two years later, Maw Hale was there to wish me Godspeed. And as the years have gone by and the experience of practice has accumulated, I never have forgotten the injunction of the wise teacher, “None of your d—business if you think the patient is dying, take off your coat and go to work!”

* * * * *

Dear Friends:

The story, “None Of Your Business” is an example of one type of osteopathic success stories that my wife, Honey, is looking for to complete her collection so that she can get her book published this year. This is just an example.

You all have dozens of stories from your practices, evidencing that osteopathy works. Take the trouble to write one or more down, send them to Honey at 122 Street, Kailua, HA, 96734.

If you would rather dictate the story

Classifieds

New OPP Position

A new FACULTY position in OPP. The individual will participate in OPP lectures and laboratories, work with students in the clinic, and clinical practice. The individual may also participate in departmental administration, scholarly activities, and research. The candidate will be a BC/BE DO and must be eligible for Missouri license. AOA certification in osteopathic manipulative medicine is preferred. The college is committed to excellence in its osteopathic curriculum and the further development of osteopathic research programs. Position begins July 1, 1996. Salary and rank will be commensurate with experience and qualifications. Send CV to: John Glover, DO, Chair, OPP Search Committee, University of Health Sciences, College of Osteopathic Medicine, 2105 Independence Blvd., Kansas City, MO 64124-2395. AA/EOE

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on an audio disc. do so and we’ll transcribe it.

The stories don’t have to be dramatic life saving stories. Just one of the many successes you see every day and take for granted, simply because you expect osteopathy to work.

Thanks for your help!

Cordially,
Alan R. Becker, DO
phone # and fax- 808-261-6105

Osteopathic Considerations in Systemic Dysfunction



June 28-30, 1996

Chicago College of Osteopathic Medicine
Downer's Grove, Illinois

Osteopathic Considerations in Systemic Dysfunction Registration Form

June 28-30, 1996

Chicago College
of Osteopathic Medicine
Downer's Grove, Illinois

Program

June 28, 1996

- 7:30 Continental Breakfast/Registration
- 8:00 Introduction & "The Spinal Cord as an Organizer of Disease Processes"
Michael L. Kuchera, DO
- 8:25 Axoplasmic Flow
Brian F. Degenhardt, DO
- 8:50 Pain and Referred Pain Patterns
Michael L. Kuchera, DO
- 9:30 Lecture/Lab: Chapman's Reflexes/
Diagnosis and Treatment
Michael L. Kuchera, DO, FAAO
- 10:45 Lymphatic Drainage and Improved Immune Function
Brian F. Degenhardt, DO
- 11:30 A Coordinated Approach to Dx & Tx of Patients with Systemic Dysfunction
William A. Kuchera, DO, FAAO
- 12:00 Lunch
- 1:00 Osteopathic Considerations in Cephalgia
Brian F. Degenhardt, DO
- 1:45 Osteopathic Considerations in EENT Dysf.
Michael L. Kuchera, DO, FAAO
- 2:30 Lab: OMT in EENT Dysfunction
Brian F. Degenhardt, DO
- 5:00 Course dismissed for the day

June 29, 1996

- 7:30 Power Breakfast (30 min. lecture: Nutritional Support of Homeostasis)
Ann Habenicht, DO
- 8:00 Osteopathic Considerations in Upper GI Dysfunction (General)
Michael L. Kuchera, DO, FAAO
- 8:45 Osteopathic Considerations in Upper GI Dysfunction (Applied)
Paul Jones, DO
- 9:30 Lab: OMT in Upper GI Dysfunction
Michael L. Kuchera, DO, FAAO
- 12:00 Lunch
- 1:00 Osteopathic Considerations in Lower GI Dysfunction (General)
William A. Kuchera, DO, FAAO
- 1:45 Osteopathic Considerations in Lower GI Dysfunction (Applied)
Hugh Ettlinger, DO
- 2:30 Lab: OMT in Lower GI Dysfunction
Michael L. Kuchera, DO, FAAO
- 5:00 Course dismissed for the day

June 30, 1996

- 7:30 Power Breakfast (30 min lecture: Environmental Stressors of Homeostasis)
John Hohner, DO

- 8:00 Osteopathic Considerations in Lower Respiratory Dysfunction (General)
Brian F. Degenhardt, DO
- 8:45 Osteopathic Considerations in Lower Respiratory Dysfunction (Applied)
Hugh Ettlinger, DO
- 9:30 Lab: OMT in Pneumonia and other Lower Respiratory Disorders
Michael L. Kuchera, DO, FAAO
- 12:00 Lunch
- 1:00 Osteopathic Considerations in Cardiovascular Dysfunction (General)
Michael L. Kuchera, DO, FAAO
- 1:45 Osteopathic Considerations in Cardiovascular Dysfunction (Applied)
Hugh Ettlinger, DO
- 2:30 Lab: OMT in Cardiovascular Dysfunction
Paul Jones, DO
- 4:30 Coding and questions/Answer Session
- 5:00 Course Dismissed

CME Hours

24 Category 1-A

Fees

Prior to May 26, 1996

AAO Member	\$545.00
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Residents/Interns	\$250.00

After May 26, 1996

AAO Member	\$645.00
AAONon-member	\$695.00
Residents/Interns	\$350.00

Textbooks available on site \$55.00

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Letter to A. T. Still

Component Society's Calendar of Events

Dear Doctor Still,

I think we often get too mechanical in our approach to osteopathic manipulation. By that I mean that we sometimes spend a lot of time describing vertebrae as being sidebent or rotated one way or the other, or classifying the sacrum as being in torsion or flexion or some other position; then we spend a lot of time trying to restore motion to these areas. But why? What's the purpose of all of this?

Now, I certainly feel that we have to make accurate structural diagnoses and do careful, specific manipulative treatment, but we need to keep in mind what the ultimate goal is when we are doing these things. We often speak of the goal of manipulation as being the achievement of free and unimpeded movement in all parts of the neuromusculoskeletal system. But the real goal, I think, is simply to remove somatic dysfunctions so that all of the body's systems can function at their optimum levels.

You talked about these kinds of goals when you spoke of achieving better health by influencing the fascia and lymphatics of the body with your treatments. In your book, *Philosophy of Osteopathy* (p. 260), you said: "I have thought for many years that the lymphatics and cellular system of the fascia, of the brain, the lungs, and the heart throughout whole system of blood supply, do get filled up with impure and unhealthy fluids, long before any diseases makes its appearance, and that the procedure of changes known as fermentation, with its electromagnetic disturbances, were the cause of at least ninety percent of the diseases that we labor to relieve by some chemical preparation called drugs. When I was fully satisfied that we were liable to do more harm than good with such

April 12-14

Muscle Energy Approach
Eastmoreland Hospital and Northwest
Osteopathic Medical Foundation
Portland, OR
20 Hours, Category 1-A
Contact: Al Turner, DO
(503) 230-2501

April 19-23

Sutherland Cranial Teaching Foundation
40-Hours, Category 1-A
Holiday Inn Airport
Indianapolis, IN
Contact: Judy Staser
(817) 735-2498

April 19-21

Introductory Visceral Manipulation
25 Hours, Category 1-A
Southeastern Michigan Cranial Study Group
Daniel Bensky, DO, Instructor
Ann Arbor, MI
Contact: Jay Sandweiss, DO
(313) 995-1880

May 6-7

*Applied Kinesiology: Practical Applications for
the Osteopathically-Oriented Physician*
Seattle, WA
14 Hours, Category 1-A
Puget Sound Academy of Osteopathy
Contact: Daniel Bensky, DO
(206) 517-4541

remedies, I began to hunt for more reasonable methods to relieve the system of its poisonous gases and fluids, through the excretory system of the lymphatics and other channels, through which we had hoped to renovate and purify the system."

I think we should all think of these kinds of things when we are diagnosing and treating our patients. In this way we can get beyond mechanics and work toward a more ultimate goal of treatment: bringing all of our patient's body systems to their optimum functional level.

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

May 16-19

90th Annual Convention
Virginia Osteopathic Medical Association
Colonial Williamsburg Lodge
Contact: VOMA
(804) 744-3551

May 18-19

The Cranial Base Revisited
SCTF Cranial Course, Intermediate
Sutherland Cranial Teaching Foundation and
Eastmoreland Hospital
14 Hours, Category 1-A
Contact: Al Turner, DO
(503) 230-2501

June 20-23

Basic Course, "Osteopathy in the Cranial Field"
The Cranial Academy
Holiday Inn International Drive, Orlando, FL
40 Hours, Category 1A
Contact: Pat Crampton, Executive Director
(317) 594-0411

June 21-23

Annual Meeting
Colorado Society of Osteopathic Medicine
Manor Vail Lodge, Vail, CO
18 Hours, Category 1-A
Contact: Patricia Ellis, CSOM
(303) 322-1752

August 5-9

The Expanding Osteopathic Concept, Basic
Viola Frymann, DO, Course Director
Shilo Hilltop Suites
Pomona, CA
Contact: OPSC
(916) 447-2004

August 19-26

Medical Seminar at Sea
*"Clinical Practice Guidelines and
the Language of Managed Care"*
Alaska Cruise
Holland American Line
National Osteopathic Foundation
Contact: NOF
(404) 705-9999

September 9-13

*The Expanding Osteopathic Concept,
Intermediate Course*
Viola Frymann, DO, Course Director
Shilo Hilltop Suites
Pomona, CA
Contact: OPSC
(916) 447-2004

Case History:

Somatic dysfunctions related to chronic lumbar and hip strain

by John M. Jones, III, DO

Introduction to case:

This case illustrates the evaluation, diagnosis, and osteopathic manipulative treatment of somatic dysfunctions related to chronic lumbar and hip strain.

Identification:

S.W. is a 51-year-old female optometric technician.

Chief complaint:

Pain in the right lower back and hip.

History of chief complaint:

Onset of the pain followed an accident while on a skiing trip six months prior to the first visit. The patient was parking the car on a steep driveway in front of the condominium, when she felt it necessary to get out of the car to pick something up. Either the parking gear did not hold, or she had accidentally placed it in neutral, and as she leaned against the car, it started rolling toward the condominium. She ran to the door, attempting to slide in and put her foot on the brake. As she did so, she twisted her back and right leg, and wound up half-hanging out of the car, but with her foot on the brake, saving both the vehicle and the condominium. She had an immediate onset of sharp pain in the low back, which has progressively worsened. It is now burning or electrical in nature and radiates down the right leg. She now has

accompanying pain in the thoracic and cervical regions, worse on the right side, and radiating down the right arm. The pain in the hip is dull, numbing, aching; the thoracic pain is sharp and stabbing. Tylenol and Advil taken on an intermittent basis have helped, but the pain is, if anything, worse now than at its onset.

Allergies

Codeine gives her headaches.
Desyrel gave her hives.

Medications

Premarin 0.9 mg. per day
Tylenol by box directions, prn for pain
Advil by box directions, prn for pain

Past medical history

Motor vehicle accident, 8 years previously, with no unresolved symptoms for years prior to current complaint.

Past surgical history

Tonsillectomy and adenoidectomy, 1958
Ovarian cysts removed, 1978
Total abdominal hysterectomy, 1979
Bone reconstruction, both feet, 1989

Social history

Married, optometric technician, three children (adults), admits occasional use of alcohol socially, drinks 3-4 cups of

coffee per day. Prior to accident described above, exercised at least 3-4 times per week, but not exercising at this time.

Review of Systems (positives and pertinent negatives only)

Feels depressed about the pain, which seems like it will never go away and is getting worse; has numerous other stressors, including husband's new job and son's marriage breakup with consequences for her grandchildren, and feeling her workload is too heavy at the present time, particularly because of her pain.

Physical Examination

51-year-old white female in no apparent distress. Vital signs: BP 130/80, T 98⁶, R 14, P 76. Skin: no rash or erythema. HEENT: NC/AT, EOMI, PERRLA, fundi benign, TM's clear, nares without erythema, discharge or obstruction. Pharynx without erythema or exudate. Neck supple with no JVD, bruits, lymphadenopathy or thyromegally. Heart rate and rhythm regular with no murmurs, S₃ or S₄. Lungs bilaterally clear to auscultation. Abdomen with bowel sounds present in all four quadrants, no tenderness, masses, or organomegally. Extremities present times four with no clubbing, cyanosis or edema. Tenderness at right hip, posterior. Cranial nerves 2-12 grossly intact. DTR's

2+/4 in upper and lower extremities and equal bilaterally. No loss of light touch sensation. Structural: Head rotated right and sidebent left in relationship to neck. No increased cervical lordosis, thoracic kyphosis or lumbar lordosis. Right OA myofascial hypertonicity, AA R_L, C4 ER_RS_R, T5-7 NS_LR_R, increased paravertebral fullness and tenderness, right, anteriorly rotated left innominate, short left leg (1/4").

Tender Points: A5T, right; PR5, right; Iliacus, right; A5L, right; Inguinal ligament, right; Piliiformis, right greater than left (bilaterally tender); PLT (posterior lateral trochanter), right.

Initial assessment

1. Myofascial pain syndrome
2. Pelvic somatic dysfunction
3. Lumbar sprain/strain
4. Thoracic somatic dysfunction
5. Cervical somatic dysfunction
6. Sciatica, right
7. Hormone replacement post total abdominal hysterectomy

Initial treatment plan

The patient was initially treated with strain/counterstrain and indirect myofascial release techniques, including an occipitoatlantal direct release, lumbosacral direct release, and the pelvic and lower extremity tender points. No medications were prescribed, as the patient had adequate pain relief using acetaminophen or over-the-counter ibuprofen in directed doses on a prn basis; she was also directed to use heat on the affected areas 15-20 minutes up to three times per day.

Course of treatment

On the second visit, the patient had a decrease in pain in the hip and down the left leg, but was now noticing increased thoracic, lumbar, and cervical pain, with some radiation down the right arm into the deltoid and triceps areas. Reflexes were, however, 2+/4, muscle strength 5/5 bilaterally, and there was no loss of light touch. Soft tissue techniques and

HVLA were used in these regions, which may have had elements of earlier injury (the MVA) manifesting by the second visit. On the fourth visit, muscle energy techniques were used on the cervical region, along with indirect myofascial release; articular techniques were used in the thoracic region along with strain/counterstrain; and soft tissue, muscle energy and indirect myofascial release were utilized in the lumbar spine. The treatments were at weekly intervals for the first four visits, and then were decreased to every two weeks. Gravity traction with massage was tried, as well as spinal traction with fulcrum (flexion articular technique with McManus table). The patient was prescribed abdominal exercises and cervical/thoracic/lumbosacral stretching, and amazingly, did them on a regular basis, increasing her comfort. Over the next two months, the patient was seen every two weeks, then decreased to once a month. Four months later she suffered an unrelated fall at work, injured her arm, was sent by her general practitioner for a neurological consult, and had physical therapy prescribed for the arm. She was treated by myself for her exacerbation of spinal and hip problems after the fall, returning to treatments every two weeks for several treatments. She began a swimming program with my assent. Currently she is working out on a Nordic Track under my direction, and planning to ski midwinter this year, one year and three months after starting treatment.

Discussion

This patient's case demonstrates the clinical observation that patients often note pain in other areas when their original complaints are treated and pain decreased. Masked pain is accounted for in this case not only by related somatic dysfunctions which were not part of her original chief complaints, but also by the prior history of trauma which had purportedly resolved.

The case also demonstrates the variety

of treatments which may be integrated to benefit a patient who has subclinical symptoms of sciatica, cervical radiculitis, and a myofascial pain syndrome. Soft tissue techniques were the most direct original treatment, along with direct myofascial release to the OA and LS junctions; strain/counterstrain was used liberally throughout the entire treatment; HVLA was used early and occasionally throughout the course of treatment; muscle energy and deep articular techniques also benefitted the patient.

The patient's main fear, expressed verbally on her first visit, was that she would never be able to ski again, and never again have a life rich with an abundance of physical activity. She was over fifty, and hurting so badly that her friends were all advising her that it was time to slow down and act her age. She is happy that she won't have to live up to their expectations, and having already increased her exercise, eagerly anticipates skiing this winter.

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July 16

AOBSPOMM Case History deadline

November 16-17

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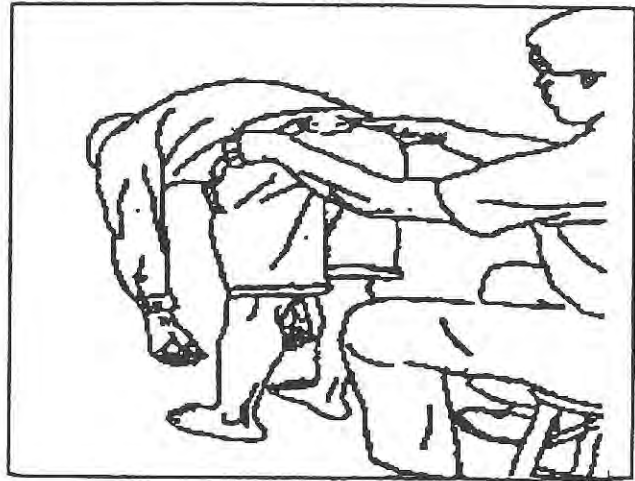
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Flexion Tests and Interpretation

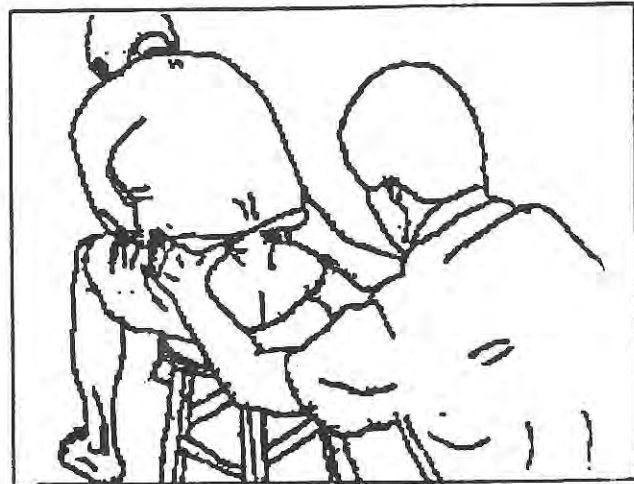
A. Standing 'Flexion Test (Iliosacral Motion)

The patient stands erect with knees extended and feet acetabular distance apart. The physician kneels behind the patient with the eyes at the level of the patient's PSIS. The physician's thumbs are placed on the posterior superior iliac spines (PSIS). The patient is asked to bend forward slowly without flexing the knees (as if to touch the toes with fingertips). During this forward-bending motion the physician observes the anterosuperior excursion of the thumbs on the patient's PSIS and notes if one side moves more anterosuperiorly than the other. The side with the greater anterosuperiorly than the other. The side with the greater anterosuperior movement is the side of the positive test, indicating ipsilateral restriction of iliosacral motion.



B. Seated Flexion Test (Sacroiliac Motion)

The patient sits on a low stool with the knees flexed to 90° and feet flat on the floor. The physician kneels behind the patient with the eyes at the level of the pelvis and the thumbs on the PSIS. The patient is asked to bend forward slowly. During the forwardbending motion, the physician observes the anterosuperior movement is the side of the positive test, indicating ipsilateral restriction of sacroiliac motion (or a bilateral restriction along the contralateral oblique axis),



C. Interpretation of Flexion Tests

A primary goal of the standing and seated flexion tests is to determine laterality of sacroiliac joint motion restriction. The standing flexion test is more attuned to the motion of the iliac on the sacrum (iliosacral motion). Thus, a positive standing flexion test would be indicative of primary dysfunction of the innominate, the pubic symphysis, or the lower extremity such as a leg length inequality. In the seated flexion test the innominates are stabilized by weightbearing through the ischial tuberosities. This test is more attuned to the motion of the sacrum between the ilia (sacroiliac motion). Thus, a positive seated flexion test is indicative of primary sacral somatic dysfunction.

When restriction of sacroiliac joint motion is present, some overlap of standing and seated flexion test results can be expected. False positive tests may also occur. For example, of the right hamstring may restrict the movement of the right innominate during the standing flexion test and cause an apparent positive test on the left side. Therefore, the standing and seated flexion tests should always be done together and the results correlated.

There are many patterns of compensation that can occur in any given patient with LLI.¹⁰ These responses are unpredictable and highly individualized. Approximately 70 percent of the population has an anatomic LLI, roughly equally distributed between left and right.^{11,12} The question then arises, "How is this related to back pain, postural decompensation and somatic dysfunction?" "What was it about this point in time that caused the person to experience pain?" "Did the pain come on gradually or was there some inciting event?" These questions are important when deciding when to initiate and for how long lift therapy should proceed.

A tip off to a possible postural component to low back pain is when there is unilateral PSIS region pain. There will be tenderness in the medial and superior borders of the PSIS. This region corresponds with the iliolumbar ligament, which is commonly strained with postural problems. Pain from this region can be localized to the PSIS or radiate to the gluteal muscles, the greater trochanter (mimicking greater trochanteric bursitis) or to the groin (mimicking the pain of a hip disorder). An anatomically short leg is commonly found in patients with a strained iliolumbar ligament.¹³

A LLI with secondary postural decompensation can cause dysfunction at any level. The person can present with upper/lower extremity pain, low back pain, thoracic back pain, cervical and suboccipital pain, or headache. You can assess each of these areas in the standing position, with special attention to primary and secondary respiration. As an example, if the patient presents with suboccipital headache and you suspect that they have an anatomically short leg as a contributing factor, you can palpate the transverse processes of C2 with your thumb on one transverse process, and your first two fingers on the other transverse process while simultaneously monitoring the sphenoid with your other hand (Fig.10). In this position you can assess the response of both primary and secondary respiration, and again you can augment this sense by having the person breath deeply.

Flexion tests can also be used at many spinal levels to assess function.¹⁴



Fig. 10 – Functional assessment of primary respiration of C₂ and sphenoid

On supine exam, if a short left leg is found by comparing the medial malleoli, then suspect an anatomically short left leg.¹⁵ In the common compensatory pattern, as described by Zink, most patients will exhibit a functionally long left leg.¹⁶ This occurs in approximately 70 percent of the population. It is common to find what appears to be an anatomically short left leg in the standing position only to find that the left leg appears to be longer in the supine position. The standing evaluation of a short leg most likely reflects a true anatomical leg length discrepancy; whereas, the supine exam most likely reflects dysfunction in the innominates, pelvis and lumbar spine (functional short leg). (This commonly resolves with manipulative treatment, unless a true LLI is present as well).

Treatment

The patient can be treated, addressing the specific dysfunctions that have been found. I have found counterstrain to be very useful in treating the iliolumbar ligament tenderpoint and relieving their low back complaints. This tenderpoint is similar to the upper pole fifth lumbar as described by Dr. Jones,¹⁷ although it may be slightly cephalad to where he describes it. I have found that with the patient prone, marked flexion of the hip (which tends to posteriorly rotate the innominate) and abduction of the hip (which tends to flare out the innominate) is very useful in reducing the tenderpoint as an alternate treatment position.

Once treatment has been completed, the patient should be re-examined in the standing position. Primary and secondary respiration and the standing flexion test are repeated and any differences noted. Many times there is a great improvement in all of these factors and no lift therapy is initiated. However, if on your standing exam you note that the sacrum and innominates are moving poorly with primary or secondary respiration, and there is still a positive standing flexion test, then lift therapy may be warranted. You may choose to see the patient for a number of treatments before initiating lift therapy.

It is helpful to have a variety of lift sizes available (size 3,5,7,9,12 mm. lifts) to assess and treat the patient. Each size lift is placed under the suspected short leg and the exam repeated. The heel lift chosen is placed under the suspected short leg and the exam repeated. The heel lift chosen is the one that provides 1) the greatest excursion of the sacrum in between the innominates with primary and secondary respiration 2) a negative flexion test, and 3) overall postural. If the examiner is not trained in the assessment of the primary respiratory mechanism, secondary respiration and the standing flexion test can be used to functionally assess and treat the patient. This same procedure can be used at any level up into the cranium.

The traditionally described method of treatment is to start out with a small lift, such as a 3mm. lift, and gradually build up the lift until the appropriate height is accomplished. It is stated that this method will decrease the side effects of having pain and discomfort in other areas as the body recompensates for

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the changing leg length. I have found that when a lift is prescribed in accordance to a functional model, that a much larger size can be initiated. The largest lift that I have put I have put in at the initiation of a therapy was 12mm., but this was an extreme circumstance. It is common for me to start patients at 5mm. or 7mm. and for patients to not complain of side effects.

When initiating lift therapy, lifts of various sizes are tried. As an example, a patient may have a left leg that is 7mm. shorter than the right. Assessment is performed, starting with a 3mm. lift and progressing up to and through the 7mm. It may be that a 5mm. lift allows the patient to have the greatest amount of function and that 7mm. actually decreases lumbopelvic function. Therefore, the 5mm. lift is chosen to initiate therapy. This is the reason that I believe that some studies on the treatment of LLI in relation to low back pain do not show as favorable an outcome. They are using a two dimensional anatomical model to treat the patient's LLI. You may be able to attain level femoral heads, sacral base, crest heights, and a straight spine, but this may actually decrease the patient's functional capacity from a primary/secondary respiration and postural point of view. An attempt to normalize the patient's posture completely is inappropriate and may cause adverse symptoms.

At each visit, the patient is re-examined with and without the lift, both before and after treatment. If on subsequent visits, (before next treatment) you examine the patient and they have a greater excursion of the sacrum and innominates and the standing flexion test is negative, a trial of no lift can be done. The physician may also have to change lift size, either increasing or decreasing as appropriate, to provide for optimum functioning as the individual changes in response to treatment.

The patient is instructed that he/she may feel discomfort in different areas as they are going through lift therapy. They may have some muscles in their back that have been chronically tightened and some that have been chronically overstretched. As the neurophysiologic mechanisms react to the changes in lift therapy, the patient's body will respond. However, I have found that treating from this functional point of view, patients seldom complain of any discomfort. I have been able to start patients with lifts that are somewhat large without any complaints.

X-Rays

Some have advocated using postural x-rays in every patient treated with a lift.¹⁹ I do not follow this recommendation. Lift therapy can be empirically tried in patients that exhibit LLI and postural imbalance. These functional tests, along with the history and physical exam, can be used most of the time when treating the patient. I order x-rays under the following circumstances:

1. Patient does not respond as expected to treatment.
2. H&P reveals clues to:
 - a. anomalies/abnormalities (i.e., spondylolisthesis, etc.)

- b. suspected fracture
- c. autoimmune diagnosis (i.e., ankylosing spondylitis)

3. Trauma.

Future Research

Any further research into LLI and lift therapy could include a functional assessment as part of the protocol for determining lift therapy. This could be combined with presently used methods as described elsewhere. I believe that a study done that includes a functional assessment of posture would show an increase in efficacy of lift therapy in the treatment of back pain and other complaints secondary to a LLI.

This paper has been an attempt to describe a functional assessment of posture as a way to guide heel lift therapy for a leg length inequality. It is a process that I have found to be very useful in the treatment of a variety of complaints, including low back pain, thoracic back pain, suboccipital pain, and headache. A functional assessment of posture takes into account both structure and function to provide optimal treatment for the patient. Heel lift therapy that solely utilizes discrepancy in anatomy as measured by physical examination or radiographs does not take into consideration function. These assessments mainly look at structure. It is through a combination of using these structural functional relationships that the greatest benefit can be attained.

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• median and medial ligaments
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Ovaries
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• chondral sternal, chondral costal, and costovertebral joints

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Received his MROF in 1966; Diploma of physical therapist in 1967 (Faculty of Medicine of Lyon, France); Diploma of Osteopathy in 1974 (European School of Osteopathy of Maidstone); Academic Director of the International College of Osteopathy of Stetienne; Chairman of the Dept. of Visceral Manipulation on the Faculty of Medicine at Paris (Nord) Dept. of Osteopathy and Manual Medicine; Lecturer at the European School of Osteopathy; author of six books; is presently in private practice in Grenoble (capital of the French Alps).

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A review of counterstrain handbook of osteopathic technique

by Ann M. Dean, DO
MSU/COM OMM resident

Editor's Note: *The authors of the Counterstrain Handbook of Osteopathic Technique are Herbert A. Yates, DO, FAAO and John D. Glover, DO. This book may be purchased from Y Knot Publishers, 7439 S, Knoxville Ave., Tulsa, OK 74136. The cost is \$ _____.*

I am quite impressed by this concise, informative, and accurate text. It is a very readable work, and would be an excellent quick reference in the clinical setting. The book is small enough to fit in a resident's pocket, if desired. Another advantage of the size is that it can be easily brought into a treatment room and used as a reference while working on a patient.

In this writing, I will describe my first impression as I read through the text. There are two parts to the text. Part one is the introduction to counterstrain which reviews the history, theory, and treatment sequence. In chapter one, an excellent historical perspective is given. It recounts the case leading to the discovery of counterstrain technique by Dr. Jones, as well as clearly describing, from a scientific viewpoint, the myofascial-neurocirculatory model upon which this technique is based. This chapter also gives a basic description of the 3-step counterstrain technique, and the discovery of the tenderpoints by Dr. Jones. I found the explanation of the difference between Jones' "tenderpoints" and Travell's "triggerpoints" very helpful. Chapter two impressed me because it starts from scratch and explains the theory. It educates the reader about general osteopathic concepts, explains the barrier concept, the difference between direct and indirect techniques and states the definition of counterstrain. The remainder, and majority, of chapter two explains the mechanism of the induction of a tender point and the mechanism of action for counterstrain technique. The myofascial-neurocirculatory model is employed here to clearly explain what is happening in the counterstrain treatment sequence. There are several article references in this part of the book. Chapter three reviews the treatment sequence. This is done in a very reader-friendly fashion in nine short pages. Chapter four explains the nomenclature/abbreviation system used in counterstrain.

Part two of the book is divided into 16 sections by body regions. Each tender point is given two pages: one page concisely gives the tender point, it's treatment and any notes or "pearls" significant to that tender point, the second page

shows a simple sketch of the operator and patient positions.

There were only a couple of items that I could say this text was lacking, or at least if they were added, they would be a nice adjunct to the contents. Those items were: 1) a glossary of terms, although most terminology was clearly explained within the text, and 2) a third chapter with case histories and/or troubleshooting for specific areas/treatments. This added chapter would be helpful to the clinician who needs help identifying situations where this type of treatment is applicable, in addition to adding confidence and motivation to actually start using the techniques. Personally, I find it helpful to draw on the practical experience of seasoned clinicians who may have more intellect and insight into an area than myself.

Overall, I believe this is a very well-written, accurate, and usable text, and I am looking forward to adding it to my library. □

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From the Archives

Osteopathy and medical evolution (1962)

The Collected Papers of I.M. Korr

Osteopathic Manipulative Therapy

Osteopathic manipulative therapy began as a central and indispensable part of a total strategy. In its countless forms it is designed to eliminate critical impediments to the optimal operation of adaptive, homeostatic, defensive, restorative, and reparative processes, thereby helping and permitting the individual to move to a physiological path more favorable to the best use and development of his biologic resources. It is not a therapeutic technique or agency for intervening in the biologic process for the treatment of this or that disease, or the elimination of this or that etiologic agent. On the contrary, it is a whole system of diagnosis, appraisal, therapy and prophylaxis, subject to infinite variety of adaptations to individual requirements, whereby favorable influences are introduced to the human organism through the manually accessible tissues of the body. Those influences cause the biologic, and therefore human, potential to more fully released more appropriately utilized and more fully expressed, in health or in recovery from ill health or in the cure that must come, if it comes at all, from within.

Osteopathic manipulative therapy is a system which purports not to make the patient well, but to help the patient get well. It is, indeed, designed to help "put the patient in command of the situation." I am convinced, from many years of close observation and some familiarity with the biologic mechanisms through which the favorable influences of manipulative therapy are mediated, that this system of therapy is a

monumental contribution to human health and welfare which is, nevertheless, still in its infancy. It can grow to healthy maturity only in the sort of medical environment that will be provided by the next higher stage of medicine, as part of a total strategy that will put it into maximal service

Unfortunately, in the prevailing purview, it has become—or certainly is in danger of becoming—only one of the long and growing inventory of therapeutic "modalities" or techniques. Not being commonly used in medical practice, it has become the differential, the symbol of distinctiveness, the "plus" in the naive "M.D.-plus" concept. It has been torn from the comprehensive man-oriented strategy in which it arose, and of which it is an essential part, and has been set in an allopathic, disease-oriented framework in which its use and development are seriously impeded, and in which it can not possibly be properly evaluated.

As an entire system of clinical appraisal and therapeutics which, according to the skills and judgment of the physician, has to be precisely "custom-made" to the patient and to his continually changing circumstances, it cannot be regarded and reevaluated as though it were a single, discrete entity, a particular drug or physical agent—any more than one could, for example, generalize about the effectiveness of "psychiatry" or "physical medicine" or "pharmacotherapy" in the treatment of a particular disease entity. To no small degree, its effectiveness, however it is measured, is determined by who does the administering.

As a whole system which must from moment to moment be adapted to the unique needs of the individual, its effectiveness can be only as great as the judgment, knowledge, and skills of the physician permit it to be. The system is of such and depth, and is such vastness and depth and is such a totally unique combination of art and science, that the necessary skills are inevitably predicated on innate ability, understanding of the system's purpose and potential, knowledge of its biologic basis and principles, continual and persistent study, and long and meticulous practice. Too often, therefore, the effectiveness of osteopathic manipulative practice is judged by the indifferent results obtained by those who do not have the requisite skills. To measure the value of the system by such criteria is very much like condemning Beethoven for every bad performance of his music. However, the more we are willing to accept bad performance, the more Beethoven's music may as well be banished!

The profession, therefore, will have to take a searching look at the premises which have permitted the centrifugal migration of manipulative therapy from the key position in a total strategy of medicine toward the palliative, adjunctive, optional periphery of clinical practice. The profession will, if it is committed to independent existence, have to take the steps to ensure the continued development of the necessary perspectives and skills among its members by appropriately designed programs of education, and to ensure continual improvement of understanding and method by appropriately designed programs of research. □

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Lawrence H. Jones, DO
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Lawrence H. Jones, DO, FAAO, originator of the counterstrain approach to treatment of somatic dysfunction, has updated his original book, first published by the American Academy of Osteopathy in 1981 under the title Strain and Counterstrain. There are a number of changes from the original text. All of the photographs have been redone to improve the clarity of the text. Another major change is the general layout. Identification of tenderpoints and positions of comfort are grouped by body region. Each point is described in a narrative form, often with clinical correlations. There is an index with the updated book

John C. Glover, DO
 Chairperson, Dept. of Osteopathic Principles and Practice
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The osteopathic physician teacher

by David N. Grimshaw, DO

Public consciousness has been raised to a level that is ideal for the sharing of a new conceptualization of health and disease. The roles of doctor and patient, the nature of our relationship, and the models we use to explain health and disease are changing. It is helpful to conceive of the physician's role as teacher. Physicians are the intermediaries for the public between medical science and the art of healing. What they can do in their daily interactions and ongoing relationships with patients is share evolving theories of the nature of illness. The public needs language to describe for themselves what is going on in their bodies. They are sufficiently educated for the most part and motivated to learn. The environment is receptive for fruitful communication to occur. Physicians have the capacity to give them language and understanding to bridge the gap of information and understanding that exists. In doing this, the goal of achieving a more comprehensive and commonly held cultural model of health and illness could be achieved with the result being a healthier population. It could also reduce the alienation that is currently felt between doctors and patients.

Fourteen years ago, I wrote a paper that sprang from my excitement with the discovery of a new model for medicine. I called it, *Holistic Medicine: Toward a New Medical Model*. It was a catalyst for me to discover the world of changing paradigms as described by Thomas S. Kuhn in his landmark book, *The Structure of Scientific Revolutions*, entered the field of osteopathic medicine because I saw in it the capacity to give my work room to grow. As the new model clearly had given me energy and lots of work to do; the field of osteopathic medicine seemed open to a different way of perceiving the role of medicine in our society. Ten years ago, Muriel Gillick wrote a comment in the occasional notes section

of the *New England Journal of Medicine*, V. 313, No. 11, 700-703 (9/85).¹ She alluded to Kuhn² as well and was discussing that "further work is needed to analyze the effect of differing conceptual frameworks on the ability of physicians to provide optimal medical care." The differing frameworks of thought, or paradigms she referred to were those held by patients and those held by physicians. The problem she identified was that many people in our culture hold belief systems about health and disease that the traditional medical community finds untenable.

Much has happened in the ten years since her letter, "Common Sense Models of Health and Disease," and much continues to be written about models and mechanisms of health and disease. The problem continues, however. A common ground of understanding between patients and their physicians about how our bodies work *does not exist*, and this disparity is a major obstacle to improving the health of our society, and preventing the spread of disease.

There is, increasingly, dissatisfaction amongst the public with medical care.³ It has been intensified by the movement toward medicine as big business and efforts toward "standardization" of medical care in terms of HMO policies and procedures, DRGs, managed care, and the buying up of physicians. These events have eroded the power and influence of physicians. They have *less* authority in the eyes of the educated public than *ever* before. It is also difficult to put trust in an insurance company, because one knows that their concern is not truly with our health.

This is fortuitous in one sense because there exists a powerful need for physicians and patients to better understand one another. The less alienation there is between doctors and patients, the more likely is the chance for the evolution of a

shared understanding of the models and mechanisms of health and disease.

Dr. Gillick implies in her letter that such a shared understanding is impossible because patients don't have a medical education or an understanding of the scientific process. However, her comment also noted that consumers of alternative practices and models are mostly college educated career persons with substantial amounts of disposable income. I suggest that such persons are excellent candidates for education about the complexities and interrelated factors that influence health and disease. People are also highly motivated to learn when presenting to a doctor with a "medical" problem. Perhaps the limitation lies with the physicians. Are doctors trained to be capable of explaining what they do in understandable language? Are they willing to share their knowledge, or is that *too* threatening to them?

When a person comes to the doctor with a complaint, it is rarely a purely "medical" problem. Its roots, pathogenesis, and manifestations occur in the context of the person's social, psychological, physical, economic family, and vocational state of affairs. When one tries to reduce health problems to purely medical or physical explanations to be able to explain the nature of the sickness under the guise of being scientific, one has truly missed the boat, so to speak. Patients today are sophisticated enough to know that kind of reduction is overly simplistic and not inclusive enough to be valid. They are not going to buy it, and the communication between them and the physician will break down. When that happens, both parties have lost, because the shared goal of health and the pursuit of truth and understanding is no longer the agenda. The relationship can then turn into a battle of wills neither party can win.

This author thinks that what in 1985

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were called by Dr. Gillick nonscientific models of disease held by patients were really just broader conceptualizations of the nature of health and disease not yet fully understood. Is it that difficult for physicians to admit they don't have all the information needed to understand the nature of illness?

Isn't it *more* appropriate to admit that we (physicians) are engaged in the practice of medicine, working always to see and understand the interrelated, connectional complexities of how the human interacts with her environment and responds to the positive and negative influences of her choices in life? Isn't it time that we recognize that western medicine, with its focus on the scientific method and an external locus of control for the development of disease processes is a limited view, albeit useful in elucidating information? When combined with and incorporating older concepts of health and disease, such as traditional Chinese medicine, with its emphasis on the locus of control being internal, influenced by the person's connection and congruence with the forces of nature, western medicine gains an added dimension. It is no less scientific. In fact, it is more complex and more closely describes reality. Both models are helpful. Louis Pasteur, on his deathbed, declared "It is the host which matters."

Osteopathic medicine has always recognized the importance of the individual, his or her "total" (physical, mental, and spiritual) well-being, being the focus of the osteopathic physician's efforts. Patient-oriented medicine is nothing new to osteopathy. The uniqueness of osteopathy, then and now, has not been due to the principles espoused, (for they were not new ideas), but due to their application to the person, perceived as whole and in the integrated use of new and old techniques in the care of the patient.

This phenomenon is already occurring, though not for the majority of persons in our culture. Many patients volunteer their observation that some doctors are better listeners and educators. They describe with gratitude how it makes them much

more confident to feel understood and to have a sense of understanding of the nature of their illness and a hand in caring for themselves. Effective compliance is most often a matter of understanding the problem and why a certain method of treatment is being utilized. The rewards for taking the time to educate and be educated are great. Being an active participant with the patient in the process of discovery, shared understanding, and treatment leading to recovery or improvement in function is the most rewarding aspect of being a physician for this author. People with an illness come into the foreign world of medicine feeling frightened, confused, powerless, helpless, and hopeless. They feel betrayed by their bodies and are often searching for more than just a "cure." They want an understanding of why, how, and what has happened.

The process physicians can lead patients through can be exciting and healing. The physician begins with discovery, sharing an understanding of the problem, getting a sense of the factors that may have contributed to its development. Once this has occurred, the patient is able to better deal with their frightening and intensely threatening situation and mount a concerted effort to overcome it. Doctors as teachers can use this opportunity to empower the patient with knowledge, hope, and motivation by giving them choices and a part in the process. After all, it is their life and their body!

As they recover a sense of control and understanding, and are able to see how the various treatments work for them, patients can choose the path that is best for them with the informed guidance of the physician. This type of relationship is rewarding for both the patient and the physician, and teaches both persons tolerance, a trait too much missing in our culture today.

Many times, the patient is surprised to be given such an important role, but most people will rise to the occasion when given the appropriate information and support. Osteopathic physicians can be qualified and equipped to function as teachers and facilitators of healing for

patients. They have been trained within a conceptual framework of health and disease that is more complex and interactive than the western biomedical model. People are eager to know more about their health and illnesses and more informed and capable of understanding than ever before. Physicians have a formidable armamentarium of tools to use to help them as well, again more than ever before. Osteopathic physicians have the additional unique skill of being able to use their hands to both diagnose more accurately and treat more effectively many illnesses that often defy less well integrated medical practitioners. The difference of expanded training in musculoskeletal diagnosis and treatment (osteopathic manipulative treatment) is an advantage, particularly since the second most common reason for persons to lose time at work and be incapacitated at home is low back pain.⁴

There exists an opportunity for physicians to function as teachers and facilitators of healing in an alliance with their fellow citizen patients as the models used to explain health and disease evolve. As these models become more sophisticated, physicians are needed who can explain their work in understandable language to their patients. In order for medical care to improve to the level it has the capacity to achieve, this alliance must become reality. Technology has advanced significantly; it is time for our ability to relate to each other and share models and understandings of health and disease to advance as well. This is a distinct aspect of medical education that needs to be addressed.

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The Concept and Technique of the Levitor Orthotic Device

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- 3:00 Biomechanical principles
- 4:00 Patient selection
- 5:00 Case history #1
- 6:00 Course dismissed for the day

July 27, 1996

- 8:00 Constructing the Levitor Orthotic Device
- 8:30 Lab: Levitor construction (partners)
- 10:00 The art of tailor-fitting, bending and pressure adjustment
- 10:30 Lab: Levitor pressure adjustment
- 12:00 Lunch
- 1:30 Radiographic measurement of postural Decomensation & documented results
- 2:00 Lab: Radiologic postural measurement
- 3:00 Spondylolisthesis
- 3:45 Case histories
- 4:30 Regional Levitor Center start-up and expectations
- 5:00 Question & answer session (or case history)
- 5:30 Course dismissed for the day

July 28, 1996

- 8:00 Patient follow-up
- 8:30 Lab: Pressure recheck: modifying size and shape of the Levitor
- 9:30 Lumbopelvic OMT (important diagnostic and treatment considerations)
- 10:30 Lab: OMT hands-on laboratory
- 12:00 Certificates distributed (course dismissed)

Course Description:

Goal: Participants in the Levitor Tutorial will qualify to be directors of certified regional Levitor Orthotic Centers with all the prerequisite knowledge and skills necessary to choose, fit, and monitor patients benefiting from the Levitor Treatment protocol. Physicians with unlimited license will be able to enroll in this program. Coding and reimbursement issues will be discussed.

CME Hours

16 Category 1-A

Fees

Prior to June 26, 1996

AAO Member	\$400.00
AAO Non-member	\$500.00
(no discounts available)	

After June 26, 1996

AAO Member	\$500.00
AAO Non-member	\$600.00

Refund Policy

All cancellations must be received in writing at least two weeks prior to the opening day of the educational program. An administrative fee of 15 percent of the total registration fee will be charged for all cancellations made prior to the cut-off date established above. No-shows and cancellations received after the cut-off day established above will receive no refund, but may transfer 80 percent of the tuition to another AAO educational program held within the next 12 months.

Attire

This course will involved actual construction of a Levitor on a partner and the opportunity to be fitted with this pelvic orthotic. There will also be hands-on OMT laboratories. For these reasons, dress should be loose fitting and informal.

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JANDA: A systematic approach to balance, proprioception and muscle function



Vladimir Janda, MD is recognized worldwide for his research linking muscle dysfunction and chronic pain syndromes. Janda emphasizes that muscle imbalances represent a systematic response of the locomotor system influencing musculoskeletal pain. Prof. Janda, along with Maria Vávrová, developed a program that uses specific techniques to restore muscle balance, joint stability and speed of muscle contraction. The *Uniplane Rocker*™ (1), *Wooden Wobble*™ (2), and *Exercise Sandals* (3) are balance devices progressively used in this program. The result is subconscious control of muscles responsible for postural maintenance

and gait. The video programs "Muscle Length Assessment" and "Sensory Motor Stimulation" guide you through initial muscle assessment and

later use of the balance devices. More information is available in OPTP's new catalog; call or write today.



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