

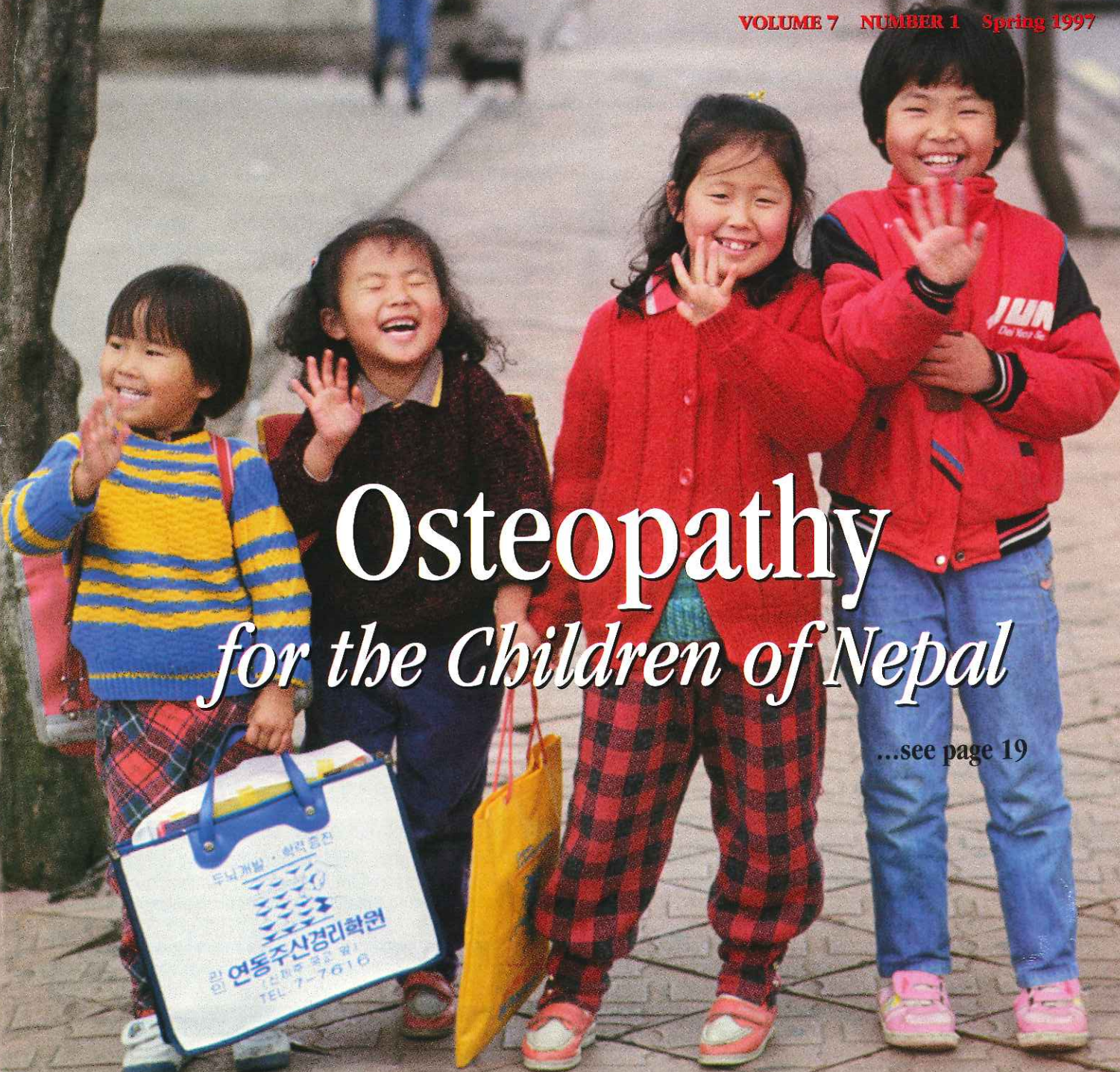
THE AAO

JOURNAL



A Publication of the American Academy of Osteopathy

VOLUME 7 NUMBER 1 Spring 1997



Osteopathy *for the Children of Nepal*

...see page 19

OMT and the McManis Table:

A Manipulative Update

April 26-27, 1997

CME Hours: 12 Category 1A

Pre-Registration Deadline:
March 26, 1997

Course Location:

Kirksville College of Osteopathic Medicine
800 W. Jefferson St., Kirksville, MO

Registration Fees

AAO Member or KCOM Alumni	\$250
AAO Nonmember or KCOM Non-Alumnus	\$350
Intern or Resident	\$100
Student	\$50

\$50.00 late fee will be added after March 26, 1997

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William A. Kuchera, DO, FAAO

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Mail Registration Information to:

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Cancellation from participants received in writing for other reasons up to 30 days prior to the course opening are subject to withholding of a 15 percent administrative fee. All other cancellations will receive no refund but may transfer 80 percent of the tuition to another AAO educational program held within the next 12 months.

Program

Saturday, April 26, 1997

- 8:00 am Introduction, history, development, status
- 9:00 am Lab: operating the table: Do's Don'ts, and special features (demonstration)
- 10:00 am Lab: McManis traction
- 11:00 am Lab: Counterstrain positioning – Part I
- 12:00 pm Lunch
- 1:00 pm Lab: Counterstrain positioning – Part II
- 2:00 pm Lab: Non-neutral Lumbar Somatic Dysfunction
- 3:00 pm Lab: strap technique
- 4:00 pm Question/answer on techniques:
Lab treatment exchange

Sunday, April 27, 1997

- 8:00 am Common Somatic Dysfunction Syndromes
- 9:00 am Lab: OMT for common Somatic Dysfunction Syndromes
- 10:00 am Lab: minor surgical and office procedures on the McManis
- 11:00 am Lecture/Lab: table availability/ treatment integration
- 12:00 pm Adjourn

Co-sponsored by
American Academy of Osteopathy and
Kirksville College of Osteopathic Medicine



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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.

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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 OMM, A-439 E. Fee Hall, East Lansing, MI 48824.

Editorial Review

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

Requirements for manuscript submission:

Manuscript

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

Computer Disks

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

Illustrations

1. Be sure that illustrations submitted are clearly labeled.
2. Photos should be submitted as 5" x 7" glossy black and white prints with high contrast. On the back of each, clearly indicate the top of the photo. Use a photocopy to indicate the placement of arrows and other markers on the photos. If color is necessary, submit clearly labeled 35 mm slides with the tops marked on the frames. All illustrations will be returned to the authors of published manuscripts.
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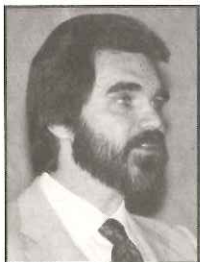
1. References are required for all material derived from the work of others. Cite all references in numerical order in the text. If there are references used as general source material, but from which no specific information was taken, list them in alphabetical order following the numbered journals.
2. For journals, include the names of all authors, complete title of the article, name of the journal, volume number, date and inclusive page numbers. For books, include the name(s) of the editor(s), name and location of publisher and year of publication. Give page numbers for exact quotations.

Editorial Processing

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

From the Editor

by Raymond J. Hruby, DO, FAAO



Great Danes, Labradors and Osteopathy

In this issue of the Journal, we include a short but penetrating story written by my friend and colleague, Karen Steele, DO, FAAO. In her article she tells the parable of the Great Danes and the Labradors, while in reality writing about the osteopathic and allopathic professions. Her point is that our profession was founded on a distinct philosophy that sets us apart from other practitioners. Her concern is that as our profession has worked to become “as good as” our allopathic counterparts we have lost some of the focus on this unique philosophy.

Dr. Steele’s article is short compared to most of the other features in this issue of the Journal. I do not wish to take your attention away from any of these other fine articles, but Karen’s story has raised some serious points and they deserve everyone’s consideration. Some of these points are ones that I have tossed around in my mind for a long time. Permit me to share some of the thoughts I had while reading Dr. Steele’s article. I offer them in no particular order. (*If you haven’t read the article yet do so now and come back to this one. It will make more sense to you.*)

First it occurs to me that most people would not seriously argue there is one ‘best’ breed of dog. No one kind of dog would be considered to be as good as or better than, any other kind. So should it be with physicians. Why should DOs even care about being ‘as good as’ MDs? The two professions are separate and distinct, and what’s so bad about that?

Second, you will notice that at no time did Dr. Steele present OMT as the distinction between the two profession, and rightfully so, in my humble opinion. Yes, there are some manipulative methods that are unique to our profession, but then, again, there are a number of health care professions that practice manual treatment or therapy of some kind. It is our unique philosophy and principles that determine when, why and how we use manipulation, and that is the critical between us and the rest of them.

Third, there is mention of how much Dr. I.M. Korr had done over so many years, not for the profession, but for what it represents. Anyone who knows Dr. Korr knows that he has been a giant in the profession for a long time. I have known him personally for some time, and I am reminded of something very eloquent he said to me when we had dinner together one time several years ago. We were talking about the profession’s push over the years to achieve parity with the allopathic profession. Dr. Korr said to me, “We spent so much time trying to become mainstream that we forgot to go upstream.” Think about it!

Finally, Dr. Steele mentions her concern that “osteopathy as a philosophy will survive, but whether the osteopathic profession will continue as its carrier vehicle is not assured.” I believe that the osteopathic profession must survive, flourish and continue as the carrier of the osteopathic philosophy. However,

this must be done not by fighting turf battles with other professions, but by becoming the leaders in promoting and teaching a new kind of health care for the twenty-first century and beyond. Andrew Taylor Still did not start out to found a new profession. He only wanted to “. . . improve our present system of surgery, obstetrics and treatment of diseases generally, and place the same on a more rational and scientific basis, and to impart information to the medical profession. . .” (*Autobiography*, p. 142). He only started a school of his own after being rejected by the established medical profession of his time.

The evidence is clear. The public wants the kind of medicine DOs know how to practice. I meet more and more MDs who attend our conferences and workshops, trying to learn our philosophy, principles, and methods. If this is what the public demands, if this is the way all physicians should practice, and if the other professions want to be like us, then the osteopathic profession must take the load and show everyone the way to a better kind of medicine. This is much different than dying on the vine for lack of progress, or being swallowed up by another profession. This is the difference between serving lunch and being lunch!

“On Great Danes, Labradors and the Osteopathy Philosophy” is a short story with a powerful message. We all need to take time to reflect on what Dr. Steele has to say. □



Message from the President

by Michael L. Kuchera, DO, FAAO

Osteopathy: Setting the Standard for the New Millennium

Osteopathic Educational Standards: Origins

This year marks the centennial of osteopathic educational standards. The American Osteopathic Association, created to assist in establishing and monitoring educational standards, was born one hundred years ago on April 19, 1897. Originally, named The American Association for the Advancement of Osteopathy, the AOA adopted its current name in 1901 and expanded educational standards in 1902. The accrediting body of the profession in the United States, the AOA remains committed to educational standards suited to a "distinctive and parallel" profession.¹ "Distinctive" in its educational emphasis and clinical application of osteopathic philosophy, principles and practice (OPP) and osteopathic manipulative treatment (OMT). "Parallel" through maintaining professional educational and clinical standards earning the same level of recognition, unrestricted practice rights, and privileges granted the majority school of medicine.

As knowledge was advanced, osteopathic standards were periodically reexamined and strengthened. In this manner, for 100 years, the designator, "osteopathic," has remained an important distinguishing feature differentiating "osteopathic" principles and practices and "osteopathic" manipulative treatment from the educational and practice standards set by musculoskeletal medicine physicians, therapists, and chiropractors for application of their manual techniques. In the United States, AOA and its standards stand behind the osteopathic appellation.

Born 60 years ago in 1937, the American Academy of Osteopathy (AA) is one of 22 practice affiliates of the AOA. Originally approved by the AOA as the Osteopathic Manipulative Therapeutic and Clinical Research Association:

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 management."

The Academy's goals and long range plan therefore complement the AOA's dissemination and implementation of the distinctive elements of the profession. Currently, the Academy is cooperating with the AOA in the development of a standardized form to record the osteopathic structural examination. Sharing an educational heritage, Academy members are specifically assigned to a number of

AOA Bureaus and Councils to generally advise and assist the AOA in assessing OPP/OMT direction and performance.

Osteopathic Educational Standards for the Millennium

Ushering in a new millennium typically involves completing tasks and setting new far-reaching visionary goals. The osteopathic profession has dedicated itself to these processes. The AOA Textbook, *Foundations for Osteopathic Medicine* (1997), was created largely through consensus of AAO leaders sitting on the Educational Council on Osteopathic Principles (ECOP). Published by Williams & Wilkins, this text is designed to be the undergraduate standard for teaching OPP and OMT. The millennium class of 2001 will be the first osteopathic graduates to have been trained using this text.

A detailed plan for enhancing distinctive osteopathic education can be found in the Osteopathic Graduate Medical Education (OGME) Task Force Report" of 1995 and in the evolving structures of educational consortia. Graduates of the next millennium will enter into Osteopathic Postdoctoral Training Institutions (OPTIs) representing a visionary marriage of colleges, outpatient facilities, and hospitals. The "seamless, vertically integrated osteopathic curriculum" to be created within these consortia will further enhance the educational standards of our profession. Emphasizing OPP, OMT, a culture of research and quality osteopathic clinical education, OPTI represent educational innovation at its potential best.

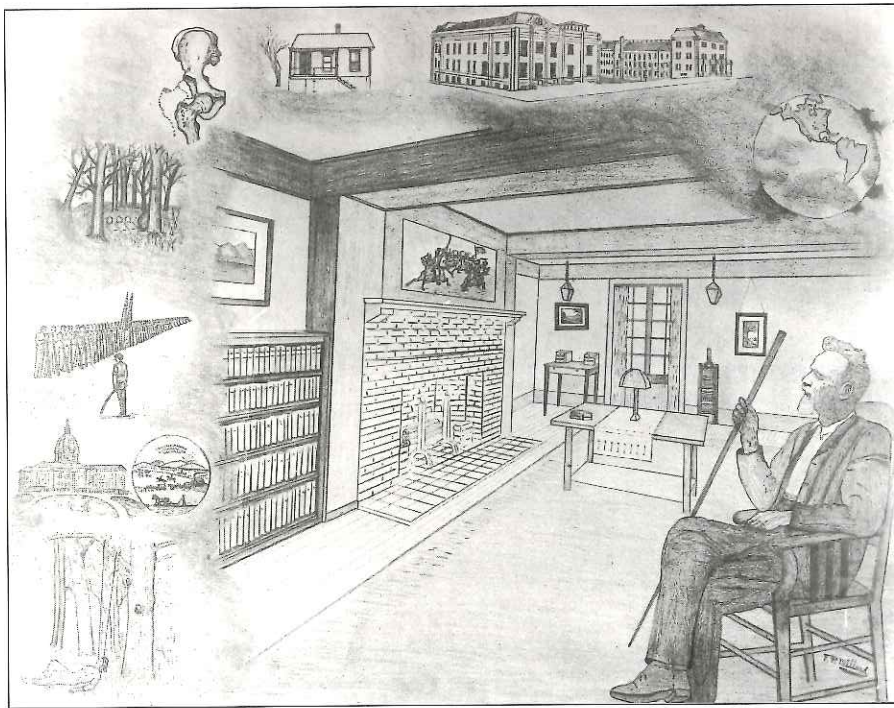
Setting the Standard for the World

From the outset in 1892, osteopathic medicine sought to influence the standard of healthcare. The founding osteopathic school was chartered with this in mind. It set as a goal:

"... to improve our present system of surgery, obstetrics, and treatment of diseases generally, and to place the same on a more rational and scientific basis, and to impart information to the medical profession."

A mechanism for "imparting information" to the medical profession sufficiently to impact their practice philosophy and style

¹Gevitz, N., "Parallel and distinctive": The philosophic pathway for reform in osteopathic medical education. *JAOA* 94(4): 328-332, Apr 1994



standard? Would such an international standard, especially if adopted by MDs in the United States, impact DOs in this country? Will we be proactive now or potentially reactive later?

The AOA is currently gathering information; it has established an international council through which this information can be processed and recommendations can be made. The AAO has positioned itself to provide such information to the AOA. As a North American representative to the International Manual/Musculoskeletal Medicine group. I will be visiting their European leadership in April in the United Kingdom along with AAO International Committee Chairperson Jane Carreiro, DO. I will also be a representative to FIMM's triennial meeting in Australia in 1998. Finally, the American Academy of Osteopathy and the American Association of Orthopaedic Medicine have jointly made a successful

bid to host the United States' first manual/musculoskeletal medicine triennial conference in the year 2001. We will be present to observe first-hand the revolution of musculoskeletal medicine standards into the new millennium; the potential for osteopathic medicine to shape the discussion on educational standards in this field is significant if we so choose.

was finally devised over one hundred years later. The AOA approved the educational standards and evaluation pathway for MDs in the United States who wish to pursue certification in special proficiency in osteopathic manipulative medicine. A minimum of 180 category 1A CME hours in basic terminology, palpatory diagnosis, and OMT with successful osteopathic completion of oral, written and practical examinations permits application to an OMM residency program. Completion of a two-year OMM residency program and other educational standards established by the American Osteopathic Board for Special Proficiency in Osteopathic Manipulative Medicine allows the MD to sit for oral, written and practical specialty examinations in OMM. If these tests demonstrate the candidate's proficiency in applying all aspects of OPP and OMT, then and only then, can an MD be certified in OMM. They will have met AOA educational standards.

The AOA has already chosen to position itself in the development of educational standards and accreditation for osteopathic medicine internationally. At the February meeting of the AOA, it charged a newly renamed "AOA Council on International Osteopathic Medical Education and Affairs" with:

At the last meeting of the physicians-only International Federation of Manual/Musculoskeletal Medicine (FIMM), the president-elect of the group approached three United States osteopathic teaching groups, including the AAO. (Through the AOA, a coordinated response was formulated and delivered). The point to be made is that osteopathic manipulative medicine, as practiced in the United States, is highly respected by American and International physicians who practice manual medicine. It is interesting that FIMM is also interested in entering the new millennium with visionary educational standards for the field of manual/musculoskeletal medicine. In their 1996 meeting, they set the goal of developing international European education and practice standards for the field — with or without our input. This brings to mind several key questions:

1. Should the United States osteopathic profession abrogate its responsibility and pass up this opportunity to lead in a field where we are perceived to be the experts?
2. Will we let allopathic teaching standards for manual medicine set by FIMM or some other group become an international

bid to host the United States' first manual/musculoskeletal medicine triennial conference in the year 2001. We will be present to observe first-hand the revolution of musculoskeletal medicine standards into the new millennium; the potential for osteopathic medicine to shape the discussion on educational standards in this field is significant if we so choose.

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"... responsibilities of oversight as to what is happening to osteopathic medicine internationally, establishing educational requirements for allowing internationally-trained candidates to apply for examination and/or licensure in the United States, and to encourage the international osteopathic schools to become complete schools of osteopathic medicine by expanding the AOA accreditation program to international schools."

The AAO representative specified by the AOA as a member of this council will be able to convey data collected by the AAO International Committee and by its international affiliates. Representatives of osteopathic medicine in the United States have been watching the accomplishments of the British osteopathic community and their dramatic, governmentally recognized inroads with great interest. The British process has been viewed as a key first step in increasing osteopathic educational and clinical standards in Europe. British osteopathic leaders will be meeting with AAO leadership at the AAO Convocation in March and in the United Kingdom in April.

Conclusion

Today is an exciting time to participate in osteopath educational standards and content. The American Osteopathic Association has

adopted a strong vision and proposal for expanding osteopathic educational standards in the United States. Furthermore, it has taken a proactive stance by positioning itself to enhance educational standards for the profession internationally. It has been given the opportunity, if it so chooses, to impact the practice of manual and musculoskeletal medicine as practiced by physicians internationally. For the AAO, long range plans currently project through the year 2000 – planning for the new millennium starts officially for us next year. To date, the Academy's long range plan has positioned

us well to assist the AOA for its role in setting the educational standards which will carry us well into the new 21st Century.

The new millennium begins January 1, 2001 and is sure to inspire the ultimate in "New Years' Resolutions." The choices we make and the long range plans we set in preparation for the new millennium are sure to affect our members and the practice of osteopathic medicine significantly. As for osteopathic standards, I hope the profession sets its sights high and aims for the world! Isn't that what a new millennium is for? □



Message from the Executive Director

by Stephen J. Noone, CAE

Five years ago, when I was preparing to take over as the Academy's Executive Director, I wrote the following as part of my message in *The AAO Journal*: "I urge you all to proclaim your uniqueness and take a more assertive posture within the profession." When I look back at that column and reflect on the progress you have made in these five years, I am proud to be affiliated with the Academy and find renewed energy from your accomplishments as I seek ways to help you shape the future of the osteopathic profession.

What has the Academy done in the way of taking "a more assertive posture within the profession?" I thought I might summarize some of *your* organization's strategies and actions in this column, particularly in light of several other columns and articles which appear in this issue of *The AAO Journal*.

The most visible evidence of this assertive posture is the rapid growth in educational programming and publishing. The AAO's Education committee has planned 24 continuing medical education (CME) programs for the 1996-1997 fiscal year as compared to three in 1992-1993. These basic, intermediate and advanced seminars focus on the practice of osteopathic manipulative medicine and are geared to both primary care and specialists physicians. Less obvious are the cooperative efforts in co-sponsorship of CME programs with the Academy's component societies as well as with AOA practice affiliates who seek to integrate osteopathic principles and practice into their own seminars.

In 1991, the Academy published the first issue of *The AAO Journal* which has steadily earned profession-wide acclamation for its quality. In 1997, Editor Raymond Hruby will implement procedures to elevate the quarterly *Journal* to a juried publication on OMM, a move which is expected to expand both national and international attention to the publication on the part of all physicians interested in "manual medicine."

In 1942, the Academy issued the first of its series of "Yearbooks" which are collections of articles relating to OMM, including original articles, others reprinted from medical publications, unpublished papers and lectures. Twelve of these Yearbooks are still in print and available to all osteopathic

physicians. There are 14 other AAO publications in print and two more scheduled for publication in 1996-1997 — *The Collected Works of Irvin M. Korr* and *The Collected Works of Viola M. Frymann*. The AAO has also become a distributor for nine other works printed by small publishers, e.g. Hildreth's *The Lengthening Shadow of A.T. Still* and *Jones Strain-CounterStrain* by Lawrence H. Jones, DO, FFAO. While this does not represent all of the osteopathic literature in print, it does substantially cover the waterfront of OMM publications. The fact is that other authors are now approaching the Academy to become a publisher or distributor of their works.

Personally, I believe the most significant achievement has been the increased presence and recognition of Academy representatives in national osteopathic leadership meetings. The organization has become highly visible and respected within the profession, primarily because the Academy has consistently assumed a cooperative stance in working with the AOA and its affiliates. AAO leaders actively participate in AOA Board of Trustees meetings, the Council on Federal Health Programs, the House of Delegates and Graduate Medical Education Conferences. AAO representatives have assumed leadership and advocacy roles in other AOA venues, including the Bureau of Research, Bureau of Osteopathic Specialists, Bureau of Healthcare Facilities Accreditation, Council on Postdoctoral Training and the Federation of Osteopathic Specialty Societies. AAO leaders serve the osteopathic profession well in coding and reimbursement issues as advisors to the AOA Division of Payor Relations and as expert representatives to the American Medical Association and the federal Health Care Financing Administration. The *real change* has been that your colleagues now approach the Academy for advice and counsel in matters relating to osteopathic philosophy, principles and practice.

While the progress is measurable, there are still many challenges ahead for the Academy and its members. I look forward to helping you build on your achievements as you confront these challenges and work to advance the profession into the new millennium. □

AAO's CME Calendar

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March

18

Grant Proposal Planning and Writing

Lynn E. Miner, PhD, Guest Speaker

The Broadmoor Hotel

Colorado Springs, CO

Hours: 16 Category 1A

19-22

Body, Mind, and Spirit

1997 Annual Convocation

John M. Jones, III, DO, Program Chairperson

The Broadmoor Hotel

Colorado Springs, CO

Hours: 31 Category 1A

April

26-27

OMT and the McManis Table (Basic)

Michael L. Kuchera, DO, FAAO, Program Chairperson

Kirkville College of Osteopathic Medicine

Kirkville, MO

Hours: 12 Category 1A

May

2-4

Exercise Prescription for Manipulative Medicine (Basic)

Brad S. Sandler, DO, Program Chairperson

AAO Headquarters

Indianapolis, IN

Hours: 20 Category 1A

16-18

Muscle Energy Tutorial (Basic)

Walter Ehrenfeuchter, DO, FAAO, Program Chairperson

Airport Holiday Inn

Indianapolis, IN

Hours: 20 Category 1A

May continues

17-18

Advanced Percussion Vibrator (Fulford's Method)

Richard M. Koss, DO, Program Chairperson

Robert Fulford, DO, Featured Faculty

Airport Holiday Inn

Indianapolis, IN

Hours: 15 Category 1A

June

27-29

Osteopathic Considerations in Systemic Dysfunction

Michael L. Kuchera, DO, FAAO, Program Chairperson

UHSCOM

Kansas City, MO

Hours: 20 Category 1A

July

25-27

Myofascial Release

Judith O'Connell, DO, FAAO

UNECOM

Biddeford, ME

Hours: 20 Category 1A

September

5-7

Urogenital-Abdomen Visceral Manipulation (Intermediate)

John L. Glover, DO, Program Chairperson

Location TBA

Indianapolis, IN

Hours: 20 Category 1A

18-21

Fall OMT Update (Intermediate)

Ann Habenicht, DO, FAAO, Program Chairperson

The Contemporary (Walt Disney® Resort Hotel)

Orlando, FL

Hours: 22 Category 1-A

Osteopathic Medical Profession: Who are we & Where are we going?

A student perspective

Binyomin M. Nemon, MS-IV
New York College of Osteopathic Medicine

***D**ue to the increasing recognition of equality with allopathic physicians, the osteopathic profession has reached an identity crisis, sending mixed messages to osteopathic medical students. In order to determine the attitude of osteopathic students, the author, a fourth-year student at New York College of Osteopathic Medicine, surveyed the second, third and fourth year classes at NYCOM (during his second year) as to their beliefs and perceptions pertaining to osteopathy, their osteopathic medical education, and future graduate medical education. Results of those responding showed that although most students entered medical school allopathically oriented, the educational system has had a good degree of success in instilling osteopathic values and an appreciation of osteopathic manipulative treatment. Yet, the system's success has been shown to be far from complete, as the majority of students' commitment to osteopathy is uncertain at best, due to the profession's identity crisis. The author concludes that serious changes will need to be instituted in the educational system in order to produce more committed DOs and ensure the future vitality of this profession.*

The title is posed as a question, because I, as an osteopathic medical student, ask you, the physicians, the educators, and the leaders of this profession, this poignant question. As the osteopathic medical profession has made tremendous strides in gaining acceptance and recognition in an allopathic world, we are approaching a crossroads regarding our identity. What is it that you are educating your students to be (as DOs)? What is it that will make us different from allopathic physicians (MDs)? What is our *raison d'être*, and where are we going?

Many journal articles have been published.^{1,2,3,4,5,6} There have been numerous meetings, conferences, and other things that seem to pass for action on this subject. Although the

profession has been aware of this problem and has been discussing it for a significant number of years², it has yet to implement a definitive solution. Two schools of thought have emerged: the "primary care focus" school and the "osteopathic principles and practices (OPP) focus" school.

Christopher Meyer, DO, most notably representing the primary care school, has written that although the niche of osteopathy was once manual medicine, the profession became uncomfortable with it and shouldered it aside to the chiropractic profession, and placed instead, an emphasis on primary care, which differentiates osteopathic medicine from the more specialty oriented allopathic medicine.³ He also writes that losing the primary care base will cause the osteopathic profession to eventually lose its market share in healthcare.⁴ Barbara Ross-Lee, DO, in the same vein, writes that although only 30 percent of the overall physician population are generalists, 60 percent of osteopathic physicians are generalists. Thus the road to our future lies in producing generalists, particularly family physicians and general internists.⁵

The OPP school position has been most eloquently stated by Norman Gevitz, PhD who believes that the profession would be making a grave mistake if it concludes that primary care, per se, can become the most important point of differentiation between DOs and MDs. He elaborates that the percentage gap between DOs and MDs in primary care is likely narrowing, and regardless of that gap, the mere percentage difference in and of itself does not ideologically justify the existence of two "distinct" professions performing the same task. He continues that it is the belief in the major role that the musculoskeletal system plays in relation to disease and health, and the palpatory diagnosis and manipulative treatment of somatic dysfunction that sets DOs

apart from MDs and justifies our professional existence.⁶

It is my belief that a key element to determining the future of the osteopathic profession is to take a realistic look at those who constitute the future of osteopathic medicine, our student population. We need to examine their beliefs and perceptions pertaining to osteopathy. Therein we will find some clues as to where we are going, what we must do, and what changes we must make, in order to appropriately guide our destiny as a profession.

To that end, during November and December of 1994, I conducted a survey of the sophomore, junior and senior classes at New York College of Osteopathic Medicine (NYCOM) on their viewpoints and beliefs pertaining to osteopathy, osteopathic medical education, and graduate medical education (GME). The results (see next page) were quite revealing. I feel that although this survey was conducted only at NYCOM, the results may be indicative of what we would find at other colleges of osteopathic medicine, particularly in light of the results of a similar survey recently conducted at an osteopathic college with very different attributes than NYCOM.

Methods

Surveys were distributed, via their school mailboxes, to 180 sophomore, and via the US Postal Service, to 160 junior and 160 senior medical students at NYCOM. The surveys contained 30 questions. The surveys that were distributed to the sophomore class contained only the first 26 statements (the 27th through 30th statements pertained to experiences

during clinical clerkships). The freshman class was not included in this survey. I felt that they were osteopathically "immature" (having matriculated only two to four months before the survey was conducted). The statements were developed by myself, with some suggestions from the NYCOM Departments of Clinical Education and Osteopathic Manipulative Medicine (OMM). The student was requested to circle a number adjacent to each statement, from one to five, indicating strong disagreement, mild disagreement, neutrality, mildly agree, or strong agreement with the statement. The students were also given a space below each statement, and requested to write any comments or explanation pertaining to their response. The anonymous surveys were returned by the sophomores to my school mailbox, and the junior and senior surveys were returned via business reply mail to myself, in care of the Department of Clinical Education. The survey results were hand tabulated and entered into Microsoft Excel® version 5.0 for analysis. The results of each class were entered separately, then combined to produce a portrayal of each class and the entire school. The two "disagree" columns and the two "agree" columns were each collapsed to single disagree and agree columns. For simplicity, the thirty verbatim statements and the collapsed results of the combined school are reported in the table (see also figure on page 12 for graphed results). Areas where class differences, and "strong" and "mild" differences were of significance are reported and discussed in the results and discussion section, where also any significant comments and explanations that were written by

the students are related. The only identifier on the surveys was as to which class the student belonged.

The goal of this survey was to assess (with a background of why students came to NYCOM as opposed to any other medical school) how the students have developed in their attitude towards osteopathic medicine, their own education, their future GME, and specifically their outlook towards osteopathic manipulative treatment and osteopathic philosophy. In short, the objective was to assess just how much of a committed DO the profession is producing.

Results and Discussion

Overall, the survey was well received by the students, although a few of them suspected me of harboring a negative bias against osteopathy. Responses were received from 53 sophomores, 47 juniors, and 55 seniors for a total of 155 respondents or a total response rate of 31 percent.

Since a quarter of the respondents did not answer the first statement (question),^a it is a strong possibility that the percentage of students just happy to be in any medical school that would admit them was actually higher. Considering that most students matriculating here wanted to go to an MD degree granting school, this school has had a good degree of success, which is demonstrated by the huge percentage of students who believe in osteopathic principles and the clinical efficacy of osteopathic manipulative treatment (OMT).^b Although the percentage of students planning to use OMT in the scope of their practice was smaller, still it was more than a bare

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a) Unfortunately because of the way that I had poorly worded the Statement (as a question), this statement, alone, among all other statements, received a 76 percent total response rate (i.e. 24 percent of all respondents did not respond to this statement).

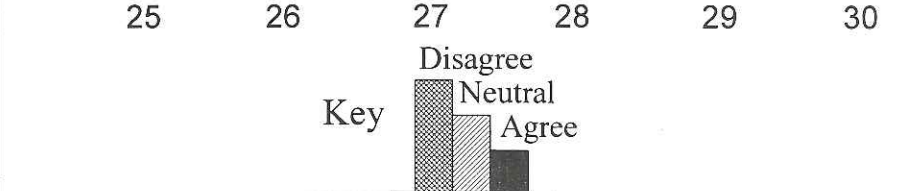
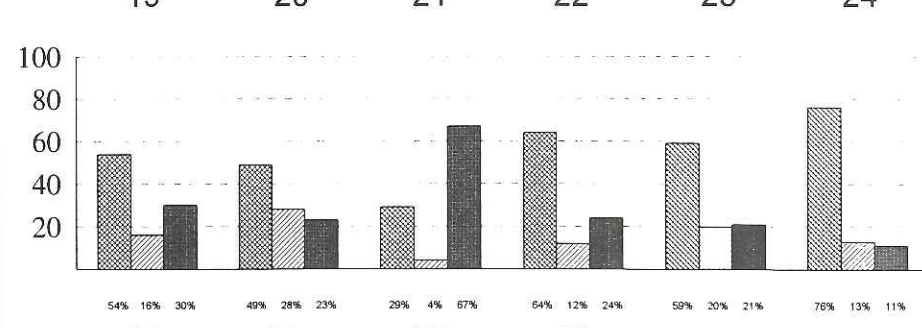
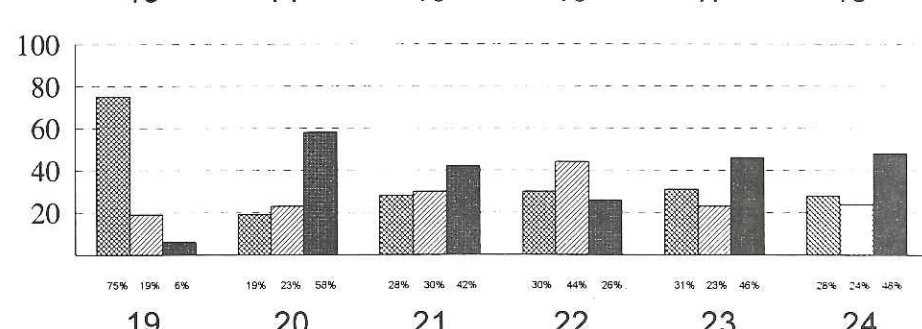
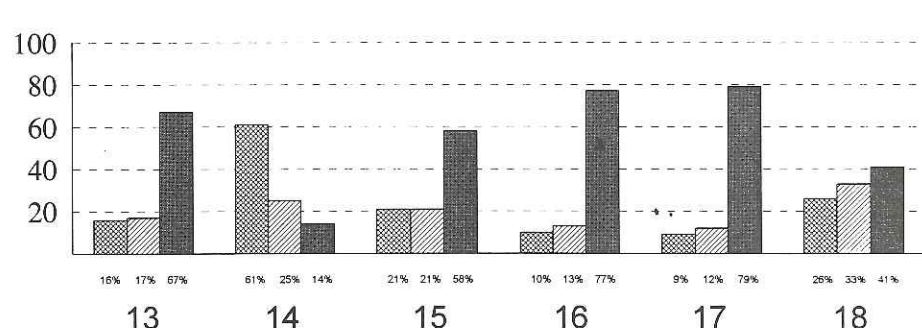
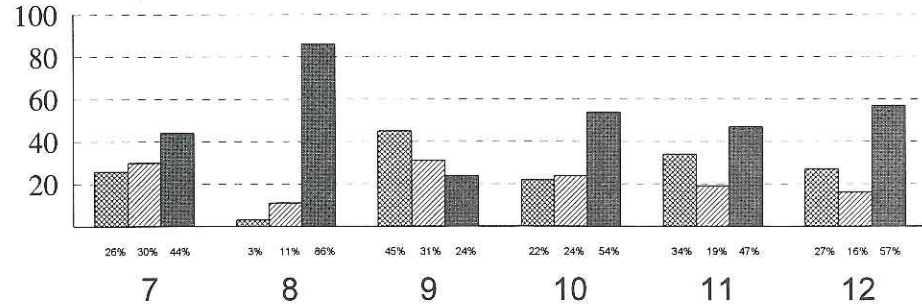
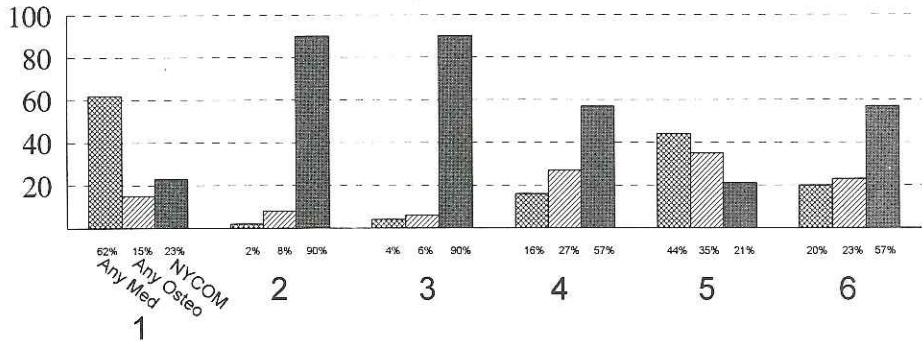
b) I wish to make a distinction between my use of the terms "OMT," "OMM," and "OPP." I used OMT to designate the *practice* of manipulative medicine, I used OMM to refer to the course taught at school, and I used the term OPP to refer to the combined philosophy, principles, and the practice of manipulative medicine.

Table
Survey of Second, Third, and Fourth Year NYCOM Students—11-12/94

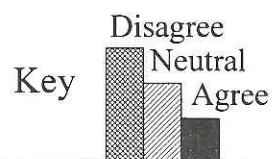
	any Med	any Osteo	NYCOM
	62%	15%	23%
1. Why did you matriculate at NYCOM? (i.e. did you want to study specifically at NYCOM, any Osteopathic school, or any medical school that you could get into?)			
	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>
2. I believe in Osteopathic principles.	2%	8%	90%
3. I believe in the clinical value of OMT and palpation skills.	4%	6%	90%
4. I plan to use OMT when I am in practice.	16%	27%	57%
5. I want to be a physician in the tradition of Dr. A.T. Still.	44%	35%	21%
6. I plan to go into primary care.	20%	23%	57%
7. I feel that Osteopathic Medicine should stress primary care.	26%	30%	44%
8. I believe in the importance of DO specialists.	3%	11%	86%
9. I feel that there should be more emphasis on OMM at NYCOM .	45%	31%	24%
10. I feel that there should be more positive reinforcement (i.e. indoctrination) of Osteopathic principles and OMT (perhaps on a personal level).	22%	24%	54%
11. I would take OMM and Osteopathic principles more seriously if there was a greater effort at reinforcement.	34%	19%	47%
12. I feel that the OMM faculty teaches OMM with enough enthusiasm and heart, and it is <i>not</i> "just a job" to them. (I feel that they care if I <i>really</i> know OMM) 00vIP	27%	16%	57%
13. Since coming to NYCOM, my attitude toward Osteopathy and OMT has become more positive.	16%	17%	67%
14. Since coming to NYCOM, my attitude toward Osteopathy and OMT has become more negative.	61%	25%	14%
15. I feel that I am competent in OMT.	21%	21%	58%
16. I care whether or not I am competent in OMT.	10%	13%	77%
17. I would like to be more competent in OMT.	9%	12%	79%
18. I feel that as a DO, I will be superior to MDs as a physician.	26%	33%	41%
19. I feel that as a DO, I will be inferior to MDs as a physician.	75%	19%	6%
20. I plan on doing an Osteopathic rotating internship after graduation.	19%	23%	58%
21. I believe that it is important for a DO to do an Osteopathic internship after graduation.	28%	30%	42%
22. I plan to do an Osteopathic/AOA accredited (as opposed to Allopathic) residency.	30%	44%	26%
23. I feel that Osteopathic residencies are qualitatively equal to Allopathic residencies.	31%	23%	46%
24. I feel that all Osteopathic residencies should stress Osteopathic principles (and OMT, if applicable).	28%	24%	48%
25. I feel that NYCOM should require a third and/or fourth year OMM clinical rotation.	54%	16%	30%
26. I feel that the Osteopathic profession should be more distinct from the Allopathic. profession.	49%	28%	23%
27. I have used OMT, palpative skills, and/or structural exams in some of my rotations.	29%	4%	67%
28. My use of OMT has been monitored, guided, or encouraged by an Osteopathic DME or other staff DO, during a rotation.	64%	12%	24%
29. My use of OMT has been discouraged or disparaged by an MD, Allopathic medical student or even my own classmates, during a rotation.	59%	20%	21%
30. I am ashamed to use OMT in front of MDs, Allopathic medical students or even my own classmates. during a rotation.	76%	13%	11%

Figure

Bar Graph of results of NYCOM Student Survey of 11-12/94



1. Wanted to study at any Medical School, any Osteopathic School, or NYCOM
2. Believe in Osteopathic principles
3. Believe in clinical value of OMT
4. Plan to use OMT in practice
5. Want to be a physician in the tradition of A.T. Still
6. Plan to practice in primary care
7. Believe that Osteopathic Medicine should stress primary care
8. Believe in importance of DO specialists
9. Believe in more emphasis of OMM at NYCOM
10. Believe in need for more positive reinforcement of OPP
11. Would take OPP more seriously if there was more positive reinforcement
12. Believe that NYCOM OMM faculty teaches OMM with sufficient enthusiasm
13. Since matriculating at NYCOM attitude towards Osteopathy more positive
14. Since matriculating at NYCOM attitude towards Osteopathy more negative
15. Believe that they are competent in OMT
16. Care if competent in OMT
17. Desire more competence in OMT
18. Believe as DO will be superior physician to MDs
19. Believe as DO will be inferior physician to MDs
20. Plan on doing AOA rotating internship
21. Believe in importance of doing AOA rotating internship
22. Plan on doing AOA accredited residency
23. Believe AOA residencies are qualitatively equal to ACGME residencies
24. Believe AOA residencies should stress OPP
25. Believe there should be a required 3rd and/or 4th year OMM clinical rotation
26. Believe Osteopathic profession should be more distinct from Allopathic profession
27. Have used OMT, palpative skills, and/or structural exams in clinical rotations
28. Use of OMT has been monitored and/or encouraged by staff DO during rotations
29. Use of OMT has been discouraged or disparaged during clinical rotations
30. Ashamed to use OMT during rotations



majority. Analyzing the responses to this statement, (#4) showed that 32 percent versus 26 percent mildly agreed versus strongly agreed. Hence with the majority of those planning to use OMT, it is unclear to *what extent* they will use it. On the other hand only 6 percent strongly disagreed, showing that very few students had absolutely no desire to use OMT. Furthermore, the overall percentage of students agreeing that they will use OMT increased by the year (sophomores 47 percent, juniors 60 percent, and seniors 65 percent, the shift was primarily from the neutral group), as did their positive belief in its clinical value (89 percent, 90 percent, and 93 percent).

Perhaps the statement of "wanting to be a physician in the tradition of A. T. Still"^c was stated a bit too esoterically for many students, based on some of the comments. Some commented on Still's rejection of drugs. I reasoned that if Dr. Still were alive today, he would have probably approved of the judicious use of today's effective pharmaceuticals. Part of the essence of Dr. Still's philosophy was about using treatments that *work*. In his days, materia medica barely worked, if at all, and mostly hurt people. Today that is not the case.

It is a reasonable assumption that intelligent osteopathic medical students understand that "being a physician in the tradition of A. T. Still" means being a physician that looks at, and treats patients holistically, and they understand that it means diagnosing and treating as a "ten fingered" osteopath first. Since most of the students were either neutral or disagreed, it must be concluded that their commitment is equivocal, as will be further demonstrated below.

The responses for "going into primary care" and "that the profession should stress primary care"^d were expected. This was consistent with commonly known percentages of DOs in, or going into, primary care.^e What was surprising was how strongly students felt (including students who themselves are committed to going into primary care) about the importance of DO specialists. Two comments that best summed up the student sentiment were that osteopathic medicine should stress educating the best physicians possible, regardless of whether specialist or generalist, and that DOs should have the opportunity to enter the world of academic medicine and represent the profession accordingly.

The responses of "need for more emphasis of OMM at NYCOM" (#9) were seemingly at odds with the responses to the next two statements pertaining to positive reinforcement of OPP. The students' comments necessitated interpretation as although the majority of students do not want a bigger workload, they still want to be better instructed and guided in OPP. Most would take it more seriously if the OMM Department made a more concerted effort at imbuing students with a greater appreciation for OPP. Notably, several students commented that we needed, during our first two years, to get extensive experience in application to outpatients, to drive home the effectiveness of OMT. After all, A. T. Still taught his students using real patients. Students felt that practicing on relatively reluctant classmates, with generally insignificant lesions, was insufficient to present the clinical

efficacy of OMT. Some students mentioned that they were convinced of its effectiveness when they had the opportunity to use OMT on patients during rotations, and on family members.

Although the majority of the students felt that the OMM faculty teaches with sufficient enthusiasm, (#12) many felt that it was often not apparent perhaps due to insufficient time, volume of students, and use of a "cookbook approach" to teaching OMM. In other words, the department is overworked and understaffed. Some felt that some instructors showed a degree of cynicism due to the apparent disinterest of many students. A number of students expressed disappointment in the fact that although they truly want to learn OMM, the material was not coming easily to them and the faculty did not bother to make sure that they were learning it properly (again the problem of overworked, understaffed faculty).

Although most students' attitudes towards OPP have become more positive since coming to study at NYCOM, (#13 and #14) there were those who said that their attitude became negative due to perceived apathy on the part of the OMM faculty and lack of meaningful instruction (as discussed above). Noteworthy were the comments of several students pertaining specifically to osteopathic manipulation in the cranial field. A significant number of students complained that they were just not feeling anything in cranial manipulation. Students felt, as a result of not picking up on its subtleties, that cranial manipulation is "voodoo" and "quackery."

c) One student commented positively, also in the tradition of William G. Sutherland, DO.

d) One student suggested that this is an economically motivated bias on the part of the schools and the AOA.

e) As quoted above from Dr. Ross-Lee, and will be shown again below.

f) A student here suggested that osteopathy ("Stillism") is a cult. I must respond emphatically to this, that it is not. To me the word cult smacks of religion. I am a firm believer in osteopathy, but my religion is *not* A. T. Still's religion, nor are Still's religious beliefs compatible with my own. Still was a Methodist, son of a Methodist preacher, and I am an orthodox Jew and a rabbi.

A majority of students felt that they are competent in OMT (#15). It was refreshing to note that a strong majority care about their competence, and want to be more competent in the use of OMT (#16 and #17).

The largest segment of students, although not the overall majority, felt that as DOs they would make superior physicians to MDs (#18). Curiously, this percentage rose from 32 percent in the second year to a majority of 53 percent in the third year, then dropped again to 38 percent in the fourth year. Many students who had responded neutrally or negatively said that they felt they would be equal to MDs. Other students who had responded positively, commented that OMT gave them a definite edge over the MDs. Others stated that with a considerable number of osteopathic students being older and having had "alternative life experiences," this made for a DO with better interpersonal skills.

Needless to say, the majority of students disagreed with the suggestion that as DOs, they would be inferior clinicians. The few students who agreed in the "mildly agree" category regarding DO inferiority to MDs (#19) explained their response meant a "public perception" of DO inferiority, not actual clinical inferiority. Some suggested that this was a result of lack of public exposure and awareness of DOs, and that we need to have an aggressive promotion campaign. As for "strongly agree" in this question, only two students in the whole school responded such.

The 58 percent responding overall positively about planning to do an AOA

rotating internship (#20) was misleading because the figures from the junior and senior classes were 68 percent and 78 percent positive. Evidently, the large percentages of negative and neutral responses of the sophomores (28 percent and 43 percent) were due to the erroneous impression among sophomores that "osteopathic internship" meant doing an "OMM internship." This seniors' figure tallies quite well with the following facts. From the NYCOM class of 1994, 80 percent of the graduates took AOA internships.⁷ Nationally, in the year 1993-94, 73 percent of all osteopathic graduates took AOA internship positions.⁸ Yet a number of students expressed disappointment that OPP is not stressed during internships. Others expressed that their main motivation for taking an AOA internship (#21) was for "political reasons" (pressure from the school and the desire to remain in the good graces of the AOA).

Yet, the percentage of students responding positively to taking an AOA residency was a definite minority. The responses changed significantly by the year. In the sophomore class the greatest percentage was neutral (55 percent), not having any serious hospital exposure. By the senior year, the greatest number was negative (42 percent), with only 23 percent responding positively. We see indeed that the graduates have voted with their feet. From the NYCOM class of 1993, only 20 percent (28 out of a class of 138) elected to enter AOA accredited residencies.⁹ Nationally a total of 3,086 DOs (1,208 in internships [excluding military] and 1,878 in residencies) were in AOA accredited GME programs,⁸ while 3,296 DOs were in ACGME

approved GME programs.¹⁰ In other words, during that year, approximately only 48 percent of DOs in GME training were in AOA programs. Even in primary care, a territory that many DOs wish to claim as our own, there were 1,669 DOs in training in ACGME primary care (family practice, internal medicine, pediatrics, and obstetrics and gynecology) residency programs versus 810 DOs in training in the same AOA residencies, in the year 1993-94.^{8,10g}

In many of the non-primary care residencies, the ACGME versus AOA numbers are similar: anesthesiology (359 vs. 85), cardiology (91 vs. 39), neurology (88 vs. 21), pathology (52 vs. 3), physical medicine and rehabilitation (119 vs. 0),^h and psychiatry (236 vs. 43).^{8,10} As a matter of fact, DOs were found in almost every type of ACGME residency. The few ACGME residency programs that DOs *seemed* to be locked out of were some surgical subspecialties such as neurosurgery,ⁱ hand surgery, thoracic surgery, and vascular surgery, where no DOs were to be found training in the year 1993-94, while there were foreign medical graduates found there.¹⁰

The above correlates quite well with the less than majority positive response (47 percent), that were received to whether the students thought "that AOA residencies are qualitatively equal to ACGME residencies" (#23). The percentages did not differ greatly by class. Many students commented that they would apply for the best training possible. One student commented that taking an AOA residency was tantamount to professional suicide. Student impressions aside, the facts

continued on page 30

g) It can be seen that if 1,208 osteopathic interns constitute 73 percent of all DO PGY-1's, then approximately a total 1,655 DOs (these figures exclude military) were in PGY-1. Subtract that number from the combined total of DOs (3,086 AOA + 3,296 ACGME = 6,382) in GME programs that year, shows that approximately 4,727 DOs were in post PGY-1 residencies that year. Use this number to divide the total number of DOs that were in primary care residencies (810 AOA + 1,669 ACGME = 2,479), and we will see that approximately 52 percent of all DOs in residencies were in primary care positions, in 1993-94. This is approximate, because we don't know exactly how many of the ACGME residency positions were in PGY-1.

h) Although there was one osteopathic psychiatry residency program at the time, nobody was in it.

i) This is changing, too. One 1993 NYCOM graduate is in an allopathic neurosurgery residency program.

Letter to A.T. Still

ENCOURAGE
YOUR COLLEAGUES
TO BECOME
OMM CERTIFIED!
DATES TO REMEMBER

**PLEASE NOTE
CHANGES
IN DATES**

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Osteopathy**

3500 DePauw Blvd., Suite 1080,
Indianapolis, IN 46268-1136
Phone: (317) 879-1881 or FAX: (317) 879-0563

Dear Doctor Still,
I have often wondered how much you knew about what we now call "Osteopathy in the Cranial Field." You know, of course, that one of your students, William Garner Sutherland, DO, took the principles you taught him and applied them to the head. He discovered and developed a brilliant model of what we call the craniosacral mechanism. The techniques he developed to treat dysfunction of this system are practiced by many today.

You did not seem to have much to say about the craniosacral system. I have always suspected that you knew much more about this concept than you were willing to discuss. For example, I know that you often talked about the brain as being the power source for the rest of the body. You also said that "... the cerebrospinal fluid is the highest known element in the human body, and unless the brain furnishes this fluid in abundance a disabled condition of the body will remain" (*Philosophy of Osteopathy*, p. 39). You also had occasional comments about the head and neck area that would indicate that you knew that such a craniosacral mechanism must exist. For example, in *Research and Practice* (p. 65) you said: "I want to insist on bringing to your attention the importance of treating diseases of the head, of keeping the road from the heart to the brain open and

in first-class condition for the passage and delivery of pure arterial blood to the head. The free and unobstructed return of the venous blood is just as important. This law is exact and absolute and if you want perfect hearing, vision, smell, taste, feeling, you much have good nourishment, pure abundant arterial blood, nerve fluid, and an open way for venous return."

Yet, I wonder why you did not have more to say on this important topic. Perhaps you saw that Dr. Sutherland would expand the osteopathic concept as he did, and thus you did not need to worry about it. This would certainly be consistent with your method of teaching. Truhlar (*Doctor A. T. Still in the Living*, p. 140) has quoted you as saying "I have only gotten the squirrel's tail out of the hole in the tree and that it was up to us, his graduates, to 'dig on' and pull the remainder of the squirrel out of the hole."

Dr. Sutherland proved himself to be one of the truly original thinkers of the world just like yourself. The more I study his work, the more I wonder about what you knew about the system he eventually developed. Perhaps there is more in your writings than I am able to discern. I will keep trying.

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



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Program

May 2, 1997

Morning Session - 8:00 am

1. Principles of motor control
2. Structural examination
 - a. Purpose
 - b. lab session

Lunch - 12:00 noon

Afternoon Session - 1:00 pm

1. Neuromotor Regulation
 - a. sensorimotor exam and retraining
 - b. concepts and principles regarding muscle imbalances
2. Evaluation & treatment of lower quarter
3. Identification of faulty movement patterns
4. Practice Session
5. Assessment of muscle length and treatment by manual stretching
6. Self stretching exercises and retraining
7. Practice Session

Adjourn - 5:00 pm

May 3, 1997

Morning Session - 8:00 am

1. Evaluation & treatment of upper quarter
2. Identification of faulty movement patterns
3. Practice Session

Lunch - 12:00 noon

Afternoon Session - 1:00 pm

1. Self mobilizing exercises for specific joint dysfunctions
 - a. cervical spine
 - b. thoracic spine
 - c. lumbar spine
 - d. SI joint and pelvis

Adjourn - 5:00 pm

May 4, 1997

Morning Session - 8:00 am

1. Sequencing home exercise programs and dosage
2. Reevaluate partner and prescribe an individualized home exercise program
3. Closing questions and comments

Adjourn - 12:00 noon

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Letters to the Editor

Dear Dr. Hruby,

I first met Vic Hoefner in Colorado in the 1970s, when the American Academy of Osteopathy had their meetings there. He had been a longtime practitioner, and his leadership and professionalism struck me. We became great friends, and since that time I have had the pleasure of his being a teacher, colleague and mentor to me for almost three decades. He had been a leader in the profession and led the profession from the manual communications of the 1980s to the computer cyberspace technologies used to record and document musculoskeletal motion and function of the 1990s. He had been an example to all in his great professionalism, enthusiasm, ethics and compassion. His practice stands today as an example for all, as testimony to his life.

As long as students and practitioners of the osteopathic concepts engage the physical barrier and take the patient to the anatomical barrier, Vic Hoefner will be remembered. Passing the baton to the younger generation, this teacher of osteopathic medicine deserves the position of highest honor that we can award a practitioner.

Vic Hoefner will be missed by the entire medical community, but the examples that he set in stone in his lifetime will continue to lead the medical community for years to come.

From one generation to another, we not only can thank him for his leadership in the '80s and '90s, but for a lifetime of service. I recommend and/or propose that he be awarded our highest osteopathic award.

Sincerely,

Timothy D. Webber, DO, FAOCOPM
Past President, ACOPM

To the editor,

The article by J.M. Norton in the winter 1996 issue of the AAO Journal, titled "A challenge to the concept of craniosacral interaction," was very interesting to me. I completed a research quite like his, in 1993-95 at the end of my training in osteopathy in Montreal, and I had quite the same results.

I asked three osteopaths to simultaneously palpate the primary respiratory movement (PRM) on the same subject, one at the sphenobasilar symphysis, one at the sacrum, one at the sub-talar joint. With a silent pedal system linked to a computer, I asked them to move the pedals at the rhythm

felt in their hands. The preliminary palpation of the thoracic movement, as Dr. Norton did, proved my system to be reliable.

I found that, most of the time (92.5 percent of the time recorded), the rhythms felt were asynchronous and at different rates. My findings support those of Dr. Norton. So, I propose that we no longer use (and teach) the "membrane pulley model" or the "spinal reciprocal tension model" as being true. An "interactive model" of some kind is more in agreement with both our data.

A computerized simulation predicted that, by chance, three synchronous curves could happen 2.1 percent of the time recorded (vs. 7.5 percent in my experiment). Also, my model allowed me to observe an interesting phenomena. After a still point, the rhythms were more often synchronous, and for a longer period of time. So, it seems that the rhythms felt can be synchronous for a certain amount of time, in certain conditions. This remains to be clearly observed and proven. I also found rhythm much slower than traditionally taught. The average was 5.1 cycle/min (range 2.2 to 10.0). The signification of these findings remains to be explained.

Paul Lépine, MD, DO
Charlesbourg, Québec

Affiliated Organization's CME Calendar

April 24-28

Basic Course in Osteopathy in the Cranial Field
Sutherland Cranial Teaching Foundation
NYCOM, Old Westbury, New York
Hours: 40 Category 1A
Contact: Judy Staser
(817) 735-2498

May 29-June 1

Annual Meeting and General Practice Update
Virginia Osteopathic Medical Association
Marriott Hotel, Williamsburg, VA
Contact: Peter Gent, DO, Secy-Treas.
(804) 744-3551

June 14-18

Basic Course
"Osteopathy in the Cranial Field"
The Cranial Academy
Hours: 40 Category 1A
CCOM
Downers Grove, IL
Contact: Patricia Crampton, Exec. Dir.
(317) 594-0411

June 19-22

Annual Conference
The Cranial Academy
Hours: 40 Category 1A
Intercontinental Hotel, Downtown
Chicago, IL
Contact: Patricia Crampton, Exec. Dir.
(317) 594-0411

August 1-3

Intermediate Course "The Face"
Sutherland Cranial Teaching Foundation
Courtyard by Marriot, Lexington, Kentucky
Hours: 14 Category 1A
Contact: Judy Staser
(817) 735-2498

August 4-8

Basic Cranial Course
Viola Frymann, DO, FAAO, Course Director
Claremont, CA
Hours: 40 Category 1A
Contact: Marlene Weyuker
(916) 447-2004

August 9-10

Sutherland's Methods
for Treating the Rest of the Body
Dallas Osteopathic Study Group
Dallas, TX
Hours: 16 Category 1A
Contact: Conrad Speece, DO
(214) 321-2673

September 29 - October 3

Intermediate Cranial Course
Viola Frymann, DO, FAAO, Course Director
Claremont, CA
Hours: 40 Category 1A
Contact: Marlene Weyuker
(916) 447-2004

October 10-12

Continuing Studies "The Cranial Base Revisited"
Sutherland Cranial Teaching Foundation
UNECOM, Biddeford, Maine
Hours: 16 Category 1A
Contact: Judy Staser
(817) 735-2498

Osteopathy for the Children of Nepal

by Averille Morgan, BAppSc (Osteopathy), MAOA, MACA

This paper compares the necessity and acceptance of osteopathy with the variety of medical systems used in the care of the Nepalese people, with emphasis on neonatal and pediatric health care.

Introduction

The Kingdom of Nepal, nestled in the Himalayan mountains between India and China, still exhibits a symbiotic coexistence of a hard-working and resourceful people with a rugged but bountiful land. The Nepalese people of today are a confluence of many religions (Buddhism and Hindu), races (Indo-Aryan of India and Tibeto-Burman of the Himalayas) and languages.

Nepalese health care has been influenced by Indian (Ayurvedic) and Tibetan/Chinese medicines over the last century and has more recently included allopathic and homeopathic medicines from the west. Manual therapy is practiced by Tibetan healers (jhantri) in mountain regions and "bone-setters and barbers" in the streets of Katmandu. It has been suggested that in the light of changing medical trends, the ancient manual system of treatment is in "danger of being overwhelmed or forgotten."²

A study of the health care of Nepalese children was this author's primary concern. The integration of osteopathy for the treatment and prevention of childhood disease into the established sociocultural system was explored.

Materials and Method

Observation and discussion of neonatal and pediatric health at the Obstetrics department at Tribhuvan University Teaching Hospital (TUTH) and the Pediatric department at Kanti

Children's Hospital, Katmandu, was conducted for two weeks in the winter season of 1995. Medical discussion and hospital rounds were conducted in association with Dr. Shrestha of the pediatrics department at Kanti.

Further observation of manual therapists at the Ayurvedic Hospital of Katmandu, Swayambhunath temple in the Katmandu valley, the Tibetan refugee camp in Patan, several nursing mothers and the "medicine" women in the Annapurna region northeast of Pokhara was conducted over the following six weeks.

Description of patient medical conditions and treatment were discussed in English and modification of osteopathic terminology³ enabled an easier interpretation of the manual osteopathic approach. Communication with the Nepalese "medicine" women was limited to translation of key descriptor words in Nepali and by manual participation to understand physical changes made with treatment.

Results and Discussion

Education and improvement in technology in the Katmandu valley over the last twenty years has increased awareness and acceptance of allopathic medicine in the Nepalese health care system. At TUTH more emphasis on the treatment and management of children under twelve months of age caused the recent establishment of the "baby clinic"

program with free assessment and vaccination of babies, delivered at TUTH. Volunteer medical teams from TUTH and Kanti hospital participate in medicine "camps" which visit nominated mountain villages on the outskirts of the Katmandu valley and provide allopathic treatment for women and children.

Currently manual therapy within the TUTH and Kanti hospital systems consisted of physical (physio) therapy alone. Osteopathic medicine was unknown. In order to describe osteopathy I compared Ayurvedic concept, understood by the doctors at TUTH and Kanti, whereby the "body electricity" or prana within the body runs from the sacrum to the vertex. An imbalance of prana leads to areas of dysfunction or disease. Dysfunction was then discussed in terms of viscerosomato-visceral reflexes. In a country where children are exposed to endemic enteric pathogens from contaminated food and water, their normal flora, immune system and mucosal linings are repetitively challenged. This means neural facilitation at the visceral level, where bacterial toxin stimulates visceral afferent impulse via pelvic splanchnic nerves to the corresponding somatic level, may result in muscular hypertonicity and vertebral somatic dysfunction.

Where medication would theoretically reduce the effect of the pathogen in the disease process, manual therapy

→

promotes the reduction of hyper-sympathetic activity and improve visceral and lymphatic drainage to enhance resistance to further infection.⁴

It was my understanding that the allopathic approach, as described by the hospital doctors, was complemented with the referral to traditional healing forms i.e. Ayurvedic and homeopathic medicines. However, it may be foreseen that continued urbanization and exposure to Western medicine for the people in Katmandu city continues to break down the traditional role of the Tibetan physician and shaman healers. In this context, osteopathic treatment in the hospital system could provide a reintroduction of preventative health care within the allopathic regime and perhaps satisfy the traditional understanding of balancing the prana.

The Shaman healers do not practice manual therapy,⁵ but rather dream travel, telepathy and merenpsychosis. I was introduced to two Tibetan "medicine" women in Patan and Chomrong who practiced a manual molding technique on the cranium and spine of the newborn child. (These women have no formal training but are the descendants in a bloodline of traditional healing women. Their innate healing sensitivity and learned manual skills have ancient origin and are passed on to the female descendants in an aura of mystery even to other Nepalese people).

New mothers carry on the tradition of massaging mustard seed oil into the whole body of the new baby. (Mustard seed is readily grown on the Terai to the foothills of Nepal and the oil is said to have strengthening properties for growing bones). The morning massage is conducted in the sunshine which is believed to promote strength of the liver and ligaments.^{7,8}

At TUTH neonatal ward most fullterm neonates were less than 2.0 kilograms (average weight of newborn in Nepal is 2.5 kilograms) and of 140 babies delivered in November 1995, 8 babies were diagnosed with "physiologic" jaundice. The new mothers were encouraged by the TUTH doctors to breast feed the infant immediately (a reduction in serum bilirubin levels, of

low birth-weight infants breast fed in the first two hours after birth, has been noted)⁶ and to nurse the newborn in the morning sun during the morning feed (in the Western hospital system, a reduction in the degree of hyperbilirubinemia, particularly in premature infants, by the use of continuous exposure to artificial light has been employed).⁶

The gentle slow strokes from the vertex to the feet posteriorly and then anteriorly from the feet to the forehead is followed by a circular massage with the thumb pads over the glabella (or third eye) area. More specifically the molding technique of the neonate cranium is a gentle, rhythmic circular motion bilaterally to follow the six fontanel. From my observation the massage with thumb pads started at the posterior fontanel and continued laterally to the area at pterion. Further thumb pad massage from the posterior fontanel and superiorly along the coronal suture to the anterior fontanel was repeated several times.

Massage encircling the fontanel is believed to increase the body energy to the area and linear massage stimulates meridian prana.² The kidney meridian is related to the development of the bone and posture⁷ and may be stimulated with linear strokes from the frontal bone, along the back and legs to the underside of the foot. The cranium and body massage procedure is continued until the closure of the anterior fontanel to twelve and 18 months of age.

The effect of this molding technique was explained to me as allowing the unrestricted passage of prana through the whole body and promoting spiritual balance. The proportioned tethering of the membranous and cartilaginous pre-ossseous elements of the cranium is essential for growth and development of the child.⁹

Perhaps osteopathy in the cranial field would provide the medium through which a similar physical change, as produced by the molding technique, could be conducted in the hospital setting for neonatal care of long duration. The extent of neonatal molding therapy observed and the number of children

receiving this treatment, in terms of long-term effects, is not documented. However, the similarity between the cranial molding technique observed in Nepal and cranial osteopathy cannot be overlooked. Further action to integrate this culturally significant therapy into a medical application within the Nepalese hospital system will ensure a return to manual preventative health care, if only for the children.

Women's health care during pregnancy in Nepal is limited and only 30 percent of women attending TUTH received pregnancy treatment or advice prior to delivery. Only 30 percent of all women in Nepal seek hospital delivery and high maternal morbidity and neonate mortality rates are prevalent in the mountain regions.¹⁰

The majority of presenting complaints at the time of observation of Kanti Children's hospital were of infectious origin. Lung disease (bacterial pneumonia and tuberculosis) seemed most predominant, and the incidence of hydrocephalus and meningitis was alarmingly high in children under ten years of age.

Perhaps the constant exposure of these children to smoke (wood fires for heating and cooking) and the carrying of heavy loads on the back (physically constricting the chest) contributes to the hypofusion of oxygen during respiration and increases the susceptibility of chest and systemic infection.

However, "the adaptive protective reaction might be far more damaging to the individual than the noxious agent beginning dysfunction."¹¹ A hyper-sympathetic tone reduces mucosal defense by vasoconstriction and reduced mucosal secretion in the lung and gastrointestinal linings. The normalization of vertebral facilitated segments and stimulation of venous and lymphatic drainage by manual therapy will encourage the homeostatic mechanism^{11,12} to protect mucous membranes and reduce the likelihood of further pathophysiological change due to ongoing physical demand.

Another example of the physical demand on Nepalese children is

transportation. Depending on caste, loads are carried atop the head or on the back supported by a strap across the vertex of the head. I observed the Thalakalis and Sherpa peoples of the Annapurna region carrying strap loads. Where the head strap crossed more anteriorly to the vertex, the head and neck held into flexion. This posture allows for a more anterior center of gravity and propulsive gait required for mountain climbing. Perhaps, from a cranial osteopathic viewpoint, the sustained pressure into flexion may induce sphenobasilar symphysis flexion and stimulate the choroid plexus and physiologic centers in the floor of the fourth ventricle. For the child with an extended cranial vault, the relative compression through bregma and into the sphenobasilar symphysis may challenge the articular mobility of the cranium and vertebral column, and compromise structural and physiologic resilience.

No matter the etiology nor explanation, this ancient mode of transportation has remained a viable form. Posture holds a key to balance. Osteopathy, like Ayurvedic and Tibetan/Chinese physicians, understands the importance of posture. Ayurvedic postures or "yoga positions" are suggested to achieve a position of simultaneous balance and decreased tension.² Tibetan physicians number the vertebral segments and believe these segments become solidified with meridian blockage.¹³ This concept is similar to traditional Chinese medicine where the meridians are viewed specifically as channels of circulation of Qi (energy) and blood. The channels connect with the internal organs and superficial tissues, hence stimulus to the meridian in an area of blockage, by massage and acupuncture/acupressure, will alter the circulation.¹⁴

A more specific meridian point massage is suggested for the treatment of children with illness.¹⁵ Osteopathy aims to improve the realignment of the structure and increase vascular and lymphatic drainage, enabling the innate healing process to restore the function of the tissues. The elements that shape and

maintain homeostasis are in essence the balance of mind, matter and motion¹⁶ and through manual therapy this balance may be achieved.

Conclusion

The use of manual medicine is in decline in Nepal. Currently there are no osteopaths working in Nepal.¹⁷ The integration of osteopathic medicine was discussed at TUTH and Kanti children's hospital for the treatment of neonatal and pediatric patients with much interest and debate. In terms of cost effectiveness, it could be said that osteopathy may provide a long-term benefit by means of a preventative health care approach. However, the reality in Nepal is that children in the hospitals are suffering disease processes of acute nature and have been shown to respond to the hospital treatment now in place. The current trend implies that traditional healing forms are being discarded for allopathic "remedies." Unfortunately, most children in Nepal do not have ongoing health care assessment and due to unavailability of follow-up statistics, the long term effects of the allopathic procedure is unknown. Nevertheless, osteopathy remains a viable form of manual treatment within the Nepalese sociocultural system in terms of compatibility with the more traditional forms of manual therapy. Further communication with Nepali health care institutions for the introduction of osteopathy as a medical science and manual form of treatment with their established medical paradigm is suggested.

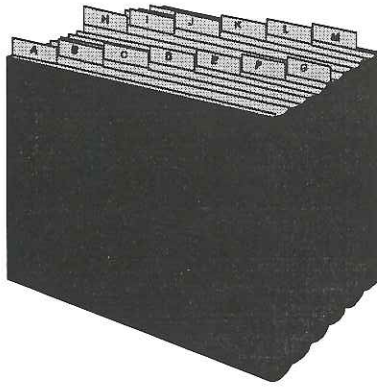
Acknowledgments

Many thanks to Dr. Shrestha and the staff at both TUTH and Kanti children's hospital for their help and discussions, Dr. J. Fendall and Mr. C. R. Morgan for reviewing my manuscript.

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Case History: Intractable Low Back Pain

by Richard M. Koss, DO

Purpose

To show the effects of osteopathic medicine in a case of intractable back pain where all of the standard allopathic procedures and therapies failed.

Chief Complaint

Intractable low back pain, with pain radiating down the right leg.

History

This 53-year-old Caucasian female evaluated in the hospital with debilitating low back pain with a duration of approximately 4 weeks. The last two weeks has gotten to the point where it is unbearable, and unable to get around the house. The pain is located in the lower back area, more on the right side, goes down the posterior and anterior portion of the legs to the heel. The patient denies any paresthesia, or paralysis except for some tingling in the right fourth toe. There is no pain on standing or rising up out of a chair. The most significant finding is tremendous amount of morning stiffness. She did have one chiropractic treatment after one week of the onset of the symptoms and made things much worse. Patient denies any significant trauma about four weeks ago when this started. It all started as a dull ache in the same area with the same distribution only severity has gradually increased. She is a general homemaker, does a lot of vacuuming, dusting and cleaning, and

also cleans her daughter's house once a week which also entails a lot of housework. She also has noted a limp in the last two weeks just prior to admission. She does wash her hair in the bathroom bending over the sink and that makes the symptoms worse. Loading and unloading the dishwasher and the dryer tends to make things worse. Patient states she has never had back pain like this before. The morning stiffness lasts about a half an hour and then starts to ease up. She also has been under a pain clinic for "migraine" headaches for which she is on Nardil and also on some Lasix and potassium for apparent swelling.

Surgical History

Includes a uterine suspension in 1959, appendectomy in 1961, had one ovary removed, total hysterectomy and the other removed in the early '60s. Sinus surgery in 1981.

Medications

Includes Lasix, potassium, Nardil and Shaklee Herbalax.

Social Habits

Includes two cups of coffee a day, denies cigarettes, alcohol or drugs. She also admits to increased weight gain over the last several years and does admit to being overweight.

Trauma History

In the late '50s had a motor vehicle accident where she rolled the car, did not have seat belt on at the time but there was no soreness or sequelae from that. In 1968 or 1969, patient was in a phone booth and the roof caved in, hit her on the top of the head. She was hospitalized for approximately one week with physical therapy in traction. Patient did note that the headaches started three to five years following this incident.

Other Illnesses

Includes migraine cephalgia, peptic ulcer disease, Bell's Palsy, obesity and obstipation.

Patient denies any exercise habits at this time. While in the hospital, she has had an injection of the sacroiliac joint with steroids as well as epidural steroids and morphine. All this according to the patient has been of no help. The history of headaches started in the early to mid '70s, described as pain in the back of the head and just above the eyebrows bilaterally. There is no prodrome, no scotomata, no aura sensation and the headaches are bad at the base of the skull. There is radiation to the forehead to the point it makes her nauseated. Her previous habit would be to remain in bed for three days with two to three shots of pain killer a day. This has been going on quite regularly on a weekly or every other week basis. Since taking Nardil, she has not had a significant

headache for about a year. As of the last two months, she has had a gradual return of some of her symptoms. She doctors in Chicago at a pain clinic.

Fractures

Right wrist only two years ago with a fall, slipping with feet going forwards and falling backwards landing on the buttocks and the right wrist outstretched.

Objectives

The patient is in no acute distress. She is moderately overweight. Patient was examined in the standing, sitting, supine, and prone positions. She is able to walk to the treatment room upright with a 5 to 10 degree forward bent position and also leaning off to the right in a psoas pattern. She does favor the right leg and cannot bear full weight on it due to the pain it creates in the low back. Deep tendon reflexes are +2/4 at the patella, +1/4 in both Achilles. Peripheral pulses are intact and bilaterally equal. There is a negative straight leg raising test bilaterally. The soft tissues around the feet and ankles are sore to palpation. There is a questionable short left leg. There are some interesting structural findings with non-neutral mechanics of both L2 and L4, being sidebent and rotated right. There is a posterior sacral margin on the right and a left sacral shear. Quite a lot of pain can be produced at the iliolumbar ligament, L4-5 area down to the sacral base on the right. The sacrum has very little motion if any in the pelvis. There is slight increased forward bending in the mid-thoracic region. Fullness and prominence of the left paraspinal musculature is noted. A very compressed OA with tissue texture changes on an old chronic nature is palpated. It is very sore to palpation. There is good cranial motion in the frontal and vertex area but does diminish as you palpate towards the condylar parts of the occiput. The patient is able to bend to about 40-50 degrees forwards while standing before the pain and muscle spasm occurs. On returning to the erect posture there is no particular soreness elicited from the patient.

X-Rays

The x-rays were reviewed. There is a questionable increase in the size of the left L5 transverse process. There is an apparent coronal facet of the lumbar spine, and the sacroiliac joints are slightly hazy. MRI was reviewed and some questionable areas of the L4-5 on the more extreme lateral slices are noted but are otherwise unremarkable. The facets are clear as well as the foramina of all lumbar vertebrae.

Consults

Neurosurgical, orthopedic, and anesthetic consults were done with no conclusive diagnosis. Trials of sacroiliac injections with steroids as well as epidural steroids were done with no success. No other significant findings were noted. Physical therapy was done on a daily basis consisting of hot packs, ultrasound, and stretching.

Assessments

1. Acute/chronic somatic dysfunction of the lumbar spine and pelvis
2. Cephalalgia by history
3. L5 radiculopathy
4. Sacroilitis
5. Obesity
6. Facet tropism of the lumbar spine and questionable increased left L5 transverse process.

Plan

OMT examination and OMT consisting of soft tissue, percussion hammer to the lumbar spine and pelvis followed by articulatory approach, supine articulatory approach to the parasagittal axis and posterior margin as well as the non-neutrals. Counterstrain to the psoas point was also performed. Indirect balancing of the sacrum was performed. Patient did report some soreness in the back of the neck and this was treated with some soft tissue and indirect fascial unwinding. Patient tolerated procedure well, was sore more on the left side as reported than the right but was able to stand more straight and

walk more symmetrical without favoring the right leg, still not adequately treated the sacral shear and we will be addressing that in the next day or so. Patient was escorted back to her room and placed in bed and instructed to remain there for an hour or so and then get up and be as active as possible. Treatment continued as an outpatient for four more visits, using the same types of techniques, soft tissue, muscle energy and high velocity low amplitude to the thorax, lumbar spine and pelvis.

Clinical Course

The patient's pain initially increased the first night and then started to subside after the second OMT. It decreased enough to be discharged on the third day of osteopathic care. After four weekly visits as an outpatient her pain decreased enough where she started back to work on a part-time basis and in three weeks was back to full-time work.

Discussion

This is a typical case of back pain where all types of therapies and procedures are employed on a trial basis in hopes to decrease the patient's debilitating back pain. It wasn't until one with a knowledge of the mechanical/functional aspects of the spine and pelvis that relief was achieved. The techniques used were not out of the ordinary, only specified to meet the needs of the patient's dysfunctional problems.

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On Great Danes, Labradors and the Osteopathic Philosophy

(A talk given at the KCOM Founders Day, October 8, 1995)

by Karen M. Steele, DO, FAAO

Dedicated to my mentors: I.M. Korr, PhD and Richard Still, II, DO

In 3000 BC there existed a beautiful dog. A large, powerful hunter and fighter. A regal dog that was commemorated in Egyptian hieroglyphics. This same dog was loved by his Chinese emperors in 1200 BC. He was taken to Europe, where he was named the Great Dane. He stood tall at his master's waist with a reserved air – a lean, handsome fighter. He was brought to America.

Another dog – smaller and of more recent heritage – and also a good hunter showed up in America. He was friendly and gregarious and devoted to his master. He was beautiful in a different sort of way. He was a Labrador retriever.

At dog shows and hunting competitions both dogs came and competed – the Great Danes in their class and the Labradors in theirs. But over time the Labradors began drawing a lot of interest, which irritated the Great Danes who had been charter members of most of the dog shows. Also, some of the Labradors were jealous of the deference given to the larger Great Dane.

So the Great Danes who were threatened by the Labradors, and the Labradors who were embarrassed to be Labradors met in secret. They agreed that any Labrador who wanted could become a Great Dane. But they must promise never to act like a Labrador again. They also must relinquish their Labrador papers and work to help close the Labrador class in all dog shows. It was agreed and one sunny day approximately 2000 Labradors became Great Danes, and X-Labradors, by decree.

This agreement angered many Labradors and Great Danes not involved in the negotiations. The Great Danes did

not want X-Labradors in their dog shows and confusing their pedigrees. And, many Labradors were happy being Labradors and feared the Labrador breed was endangered. So, this policy was stopped, and no more Labradors became Great Danes by decree.

With time, more and more Labradors saw what advantages the Great Dane enjoyed. They had the prestige of a long heritage, the imposing presence of a large dog and the air of an aristocrat. More and more Labradors decided that to be a Great Dane would be a good thing. And the Great Danes got used to having the Labradors around. They began allowing Labradors to enter the Great Dane Show Dog Training and Hunting School at an earlier and earlier age.

Gradually, with more and more Labradors training in the Great Dane Show Dog Training and Hunting School, the Labradors talked less and less about the Labrador walk, bark and friendliness. Yes, they were still Labradors – hunters and show dogs – with Labrador papers. But with so many attending Great Dane schools, the two breeds became less distinguishable. Or rather, the Labradors became more like their Great Dane teachers.

Hunters became discouraged when searching for Labradors that were good hunters and show dogs with the smallish size, friendliness and devotion to their master that had characterized the Labradors in the past. In fact, they so missed the Labradors that they demanded that the American Kennel Club set up classes for Labradors in Labrador bark, walk and hunting styles. So classes were created in Labrador, and teachers rounded up who still remem-

bered how and why a Labrador did what he did.

Some Labradors who came to the class just to get Continuing Dog Show Education credits were reminded what it was like to act and think like a Labrador. Some actually became proud to be a Labrador. Some eventually became teachers in this Labrador school. And so the breed was preserved. It would have been a shame to lose such a lovely dog just because it was not a Great Dane!

Obviously, in the story the Great Dane is our sister medical profession – allopathy, with its long heritage in the healing arts. And the Labrador represents osteopathy, a relatively recent player in the health sciences. Each are valuable. And they are distinct – or at least they were in the beginning.

I have an obvious concern about the osteopathic profession today. In our quest to become “as good as” our MD colleagues we have nearly sold our birthright. With postgraduate education in the MD community open to our graduates, 2/3 are choosing MD residencies. Predictably, as they are educated in the MD model, they practice in that model.

I believe osteopathy as a philosophy will survive, but whether the osteopathic profession will continue as its carrier vehicle is not assured. Dr. I.M. Korr has said that he has done what he has done “not for your profession, but for what your profession represents.” There is a difference.

There is a story of a wise man who was seeking the answer to the mystery of life. He ascended the mountain in which God dwelt, in spite of the efforts

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Carpal Tunnel Syndrome

by Kelly Miller, MS-IV

University of North Texas Health Science Center at Fort Worth/
Texas College of Osteopathic Medicine

Editor's Note: Kelly Miller, a recent graduate of UNTHSC at Fort Worth . . .

Introduction

The carpal tunnel canal is a passage linking the anterior compartment of the forearm with the palm of the hand. The tunnel is bounded anteriorly by the flexor retinaculum and posteriorly by the two rows of carpal bones. The contents of the tunnel include the flexor tendons of the digits and the median nerve, which traverses the tunnel immediately deep to the flexor retinaculum.¹

Any lesion that significantly reduces the size of this canal (e.g., inflammation of the retinaculum, anterior dislocation of the lunate bone arthritic changes etc.) can cause compression of the median nerve, leading to carpal tunnel syndrome. Since the nerve supplies the skin of the radial side of the palm, thumb, second and third digits, and the radial half of the fourth digit, there is often pain, paresthesia, anesthesia, or hypoesthesia in these digits.² Pain may radiate to the ipsilateral forearm. The median nerve also supplies the thenar muscles and the lateral lumbrical muscles of the second and third digits, with compression often leading to loss of strength in these digits, sometimes with wasting of the thenar muscles.² Clinical signs and symptoms, along with latencies on median nerve conduction studies, are diagnostic. The syndrome is most commonly

seen in middle-aged women.

Standard conservative treatments for carpal tunnel syndrome have included orthoses (wrist splints that prevent wrists from flexing, decompressing the tunnel; worn usually at night), antiinflammatory medications, and local steroid injections.³ Surgical treatment is division of the flexor retinaculum to relieve nerve compression, the "carpal tunnel release," which is often associated with some degree of complications. All of these standard treatments are associated with significant failure, and many patients are unwilling to receive the injections.³ However, conservative manipulative treatments and self-stretching exercises have proven to be effective alternatives in the treatment of carpal tunnel syndrome.

Case Report

Subjective: The patient is a 30-year-old white female referred to this clinic for evaluation and treatment of her "hands." The patient has noted tightness and pain in her wrist and forearms for the past two years, at least, without any precipitating episode or traumatic etiology. On this day, the patient noted tightness in her wrists, forearms, and posterior neck. She also notes occasional tingling in both arms. She gets relief with Naprelan 500 mg., which she takes about once a week, and with exercises with light hand weights. The condition is worsened by working at a computer, which she does routinely about four hours a day. Over

the past ten years, she has been a computer operator, working about forty hours/week, but she quit this job two years ago to return to college. On this day, she rated the pain as a 6 on a scale of 1 to 10. Sometimes it rates as low as a 0 or as high as a 9, on her best and worst day scenarios. On this day, she was holding both wrists in supination with mild extension, claiming that this was the position of greatest comfort.

About three years ago the patient had a motor vehicle accident which resulted in some interscapular tenderness, which she still feels is presently with her. She occasionally wears wrist splints at night. About 20 years ago she suffered a right wrist fracture, as well as a right foot fracture 10 years ago.

The patient denies any alcohol or tobacco use. Her present job is as a student at TCJC. She has an allergy to penicillin, and while she denies seasonal allergies, she admits to chronic middle ear infections. Current medications include Depo-provera injections for birth control, and pseudoephedrine 3x/week for sinus problems.

Family history is positive for cancer on her mother's side and diabetes on her father's side.

She presently does some stretching that her attending physician has prescribed for her symptoms.

Objective: Various areas of somatic dysfunction were noted: C3, RrSr; T4, RrS1; T5, R1Sr. There was a mild re-

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striction on range of motion of the forearms bilaterally, as well as in the wrists and the proximal aspect of both thumbs. Tinel's sign was negative bilaterally; Phalen's sign was bilaterally positive.

Assessment:

1. Somatic dysfunction of the cervical, thoracic, and bilateral forearm regions
2. strain/sprain of bilateral wrists
3. early carpal tunnel symptomatology, bilateral wrists

Plan:

1. Osteopathic manipulative treatment to the above-mentioned regions: myofascial release, counterstrain, and muscle energy
2. patient instructed to treat her tender points 3x daily; oral and written instructions given
3. patient given everyday stretches to do 2x daily; oral and written instructions given
4. patient given computer operator stretches to be done 2x daily; oral and written instructions given
5. patient instructed to continue wearing wrist splints at night
6. patient to return to the clinic in one week for follow-up

Review of the Literature

Dr. Benjamin Sucher, DO, has published studies of several patients with mild to moderate carpal tunnel syndrome in the *JAOA* in 1993 and 1994. He has shown that treatment of these patients with myofascial release and self-stretching yields clinical improvement, improvement in nerve conduction studies, and MRI has demonstrated increase in transverse and A/P dimensions

of the carpal tunnel.

Dr. Sucher's treatments included: 1) "opening" of the carpal canal with stretching of the flexor retinaculum to increase the space within the canal by extending digits 2-5; and 2) release of the true myofascial component of the carpal tunnel, the abductor pollicis brevis muscle, by pulling the patient's thumb into hyperextension while simultaneously performing the above mentioned stretches.³ By extending the digits and the wrist, the fascia and ligamentous structures over the canal are indirectly stretched especially distally. Additionally, the flexor tendons are pulled through the canal so that the more proximal, thicker portions of the tendons (and musculotendinous regions) are actually pulled into the canal. This begins to distend the canal from the inside, as with a bougie."³ Patients performed the stretches at home by supporting the extended digits against an object, such as a wall, and simultaneously stretching the thumb.

All patients in the studies showed signs of clinical improvement, with decreases in pain, paresthesia, numbness, and weakness, some after one treatment, some after months of treatment. In addition, all subjects demonstrated some improvement in nerve conduction study results and increase in transverse and A/P diameter of the carpal canal.^{3,4,5}

Discussion

The median nerve is easily compressed in the narrow confines of the carpal tunnel. Repetitive motions, vibrations, and trauma are among the most common causes of space-occupying lesions/inflammation of the canal.³

The manipulative treatment of the flexor retinaculum decompresses the canal, and when used as an adjunct to or in place of standard treatments, may spare many patients needless surgery.

Wrist and digit position appear to be

related to the pressure within the canal. Extremes of flexion or extension increase pressure.³ The reason may be the previously mentioned distal movement of the flexor tendons into the canal, where the more proximal, thicker portions are "stuffed" into a narrow space. This can be used to advantage to help dilate the canal, from the inside out, with hyperextension of the digits during daily stretches.³

Conclusion

Most patients actively using their upper extremities for repetitive motion are constantly flexing the wrist and carpal canal region, leading to a progressive decrease in the carpal space with adaptive foreshortening of the flexor retinaculum.³ This was the case with my patient, who worked at a computer for 10 years.

Though this patient has not had a nerve conduction study done, she exhibits many of the typical signs and symptoms of carpal tunnel syndrome. She claims that the stretches prescribed by her attending physician and exercise with hand weights help abate her symptoms. At the conclusion of one session at the clinic, which included myofascial release and stretching, the patient had increased range of motion and marked relief of pain in her upper extremities. The patient was unable to return for follow-up the following week; she has been seen at the clinic only one time.

Myofascial release with self-stretching exercises should be considered a treatment of choice for mild to moderate cases of carpal tunnel syndrome, such as this one. Nerve conduction studies and MRI before and after treatment could further establish effectiveness of these techniques. Sparing the patient recurrence of symptoms and post-op. Complications may make myofascial release of the carpal tunnel a practical and economical approach. □

Muscle Energy Tutorial

May 16-18, 1997

Indianapolis, Indiana

Program

Friday, May 16

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 17

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 18

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

Who May Attend:

Educational objectives for AAO are to provide programs aimed to improve understanding of philosophy and diagnostic and manipulative skills of DOs and individuals who possess credentials required for full licensure as physicians.

Course Objective

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

CME Hours

2.5 Days - 20 Category 1-A

Program Chair and Instructor

Walter C. Ehrenfeuchter, DO, FAAO

Advance Registration Deadline

April 16, 1997

Seminar Fee

Prior to April 16, 1997

AAO Member	\$550
Intern/Resident	\$250
AAO Non-Member	\$650

After April 16, 1997

AAO Member	\$650
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On the same weekend, time trials for the **Indianapolis 500 Mile Race** will continue. Participants could take the opportunity to visit the famed Speedway race track on Sunday afternoon and experience the drama of drivers competing for the remaining slots in the final hours of qualifications.

American Academy of Osteopathy

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Muscle Energy Tutorial Registration Form

May 16-17, 1997
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Interlinear Thinking: Are we thinking osteopathy?

by Deborah M. Heath, DO, CSPOMM

In Sutherland's book, *Contributions of Thought*, "Thinking osteopathy" meant thinking with Dr. Still. It meant thinking "between" the lines that Dr. Still wrote in *Research and Practice* and *Philosophy of Osteopathy*. He called this "interlinear" thinking. This type of thinking "seized" Dr. Sutherland's attention when, as a student, he could not reconcile the design of the beveled articular surfaces of the greater wings of the sphenoid and the squamous portions of the temporal bones to be consistent with Still's philosophy that structure and function are interrelated. "Beveled like the gills of a fish" implied respiration and motion, not immobile structures. He subsequently spent 30 years "researching" this persistent "interlinear" thought. This type of thinking allowed Dr. Sutherland's attention to be "drawn" to the potent cerebrospinal fluid, the "great river of life" that Dr. Still had referred to in earlier writings which became of fundamental importance in the cranial concept and helped advance the science of Osteopathy. Dr. Sutherland did not concern himself with the origin of his thoughts, his pursuit was to understand the thought itself in the context of osteopathy. He studied Dr. Still's writing and the available science of his time to try to make sense out of his observations and prepare his mind for thought. This process of "interlinear" thought was not confined to the laboratory but served as a tool during the therapeutic discovery process of osteopathic patient care. He studied the patient and studied the palpatory findings until his attention was "drawn" to treat a certain area often with tremendous ramifications in the healing response of the patient. His attention might have been "drawn" to a site remote from the complaint area or even a patient's thought that was important in the healing process. Once "drawn" to a particular area, the task was to alleviate or reduce the impediment to healing –

to find the health of the patient. This is part of what makes osteopathy so unique and so powerful. This is also what makes the scientific aspect of diagnostic testing, measurements, repeatability, and predictability when studying live osteopathy in the whole person a challenge.

So how does a clinical researcher proceed in the study of osteopathy? How does the inclusion of somatic dysfunction, the accessible somatic link to the clinical problem get properly incorporated into a study? How does somatic dysfunction get linked to the health of the patient? Each study is different and demands its own answers to these questions. Historically, excluding Still and Sutherland, osteopathic clinical research studies have mostly studied parts of the whole person being treated. As an example, a large study was done on the use of osteopathic manipulative treatment in low back pain where a lumbar roll was used on all patients. Besides the criticism that a specific palpatory diagnosis was not made, treating a patient with one technique in one region is not osteopathy. There are other studies that had their short comings due to several different reasons such as: a small number of patients; or no controls used; or the same examiner was used before and after treatment. Dr. Viola Frymann's study, "Effect of osteopathic medical management on neurologic development in children" published in the *JAOA*, June 1992 is a landmark clinical study and comes close to perfection in many ways such as: using a wait-list group as a control group; blinding of the investigators to different parts of the data collection and giving fairly detailed descriptions of the examination and treatment. Although "criteria" for somatic dysfunction and treatment "measures to influence bones, etc." may be debated by some, more studies performed in this manner would help advance our knowledge and support

the theory and practice of osteopathy.

What does it take to perform a quality study? Perseverance, tenacity, and determination, of course, and then sheer will power. Just ask anyone that has struggled with the process. But what leads to discovery, of understanding and insight to advance knowledge in a particular area? During the 1992 international symposium on "Nociception and the neuroendocrine-immune connection," Dr. John Harakal referred to the discovery process as, "serendipity, observations made only by the prepared mind. Preparation comes with training, not only in the art of practice but in the art of thought. Thought must be based in scientific knowledge."

However, in order to direct this knowledge to a fruitful end, the inquiry must be based in a well-formulated and precise question. The "right" question will yield the right direction for pursuit of investigation. This is seen repeatedly in our daily clinical practice when we ask the patient the question that gives a wealth of information. As one is pursuing the answer to the specific question, then one should allow the attention be "drawn" to the "flash" that leads to understanding, resolution, or the next pursuit of inquiry. Examples abound in research where inflexibility or rigid adherence to protocols "closes" routes that may have been productive. So often, unexpected or "aberrant" observations have led to understanding and insight. Consistency in a study is a necessity but a willingness to alter the focus or protocol may be useful. As long as the changes are recorded then repeatable results can be achieved. Osteopathy is a science that deals with the natural forces of the body, attentiveness to this natural world requires keen observation but also a place for it to reveal itself to the inquiring mind. It is within this context that Dr. Still's "ram of reason" is meant to help in thinking osteopathy. □

Osteopathic Considerations in Systemic Dysfunction

June 27-29, 1997

University Health Sciences College of Osteopathic Medicine
Kansas City, MO

Purpose

This 20-hour course (Category 1A) presents a practical hands-on OMT approach to everyday patient systemic complaints ranging from sinusitis to pneumonia, from gastritis to irritable bowel syndrome, and from headache to angina. The program centers on designing rational osteopathic care which can be delivered in a clinically-effective, time-efficient manner.

Clinicians will be taught to seek regional and segmental diagnostic somatic clues to enhance and speed differential diagnosis. Participants will learn to integrate:

Chapman's reflexes;
Collateral abdominal ganglia; and
Segmental diagnosis of the entire spine and sacroiliac joint

In treatment, the course will center on skills use to enhance homeostasis. Skills to be mastered during this course include:

Sphenopalatine ganglia technique;
Colleterial ganglia inhibition;
Spleen pump;
Myofascial spray and stretch;
Ischial rectal fossa technique;
Mesenteric lifts;
Rib raising;
Lymph pumps;
Liver pumps;
Diaphragm redoming; and
Direct and indirect OMT of cervical,
thoracic, costal, lumbar and sacral regions

While a number of techniques will be taught, emphasis is focused on developing skills and strategies to speed diagnosis and recovery. Residents, residency trainers and DMEs will be accorded special tips for maximizing integration of these skills and strategies into their specific program.

Internationally recognized as a leader in osteopathic research and education, Program Chair Michael Kuchera, DO, FAAO, is a frequently requested clinical lecturer. His text, *Osteopathic Considerations in Systemic Dysfunction*, is the standard for many osteopathic schools, internships and residency programs. The program faculty are all experienced clinical educators who daily teach this approach to osteopathic pre- and post-doctoral physicians.

Please call:

American Academy of Osteopathy
for registration and program information: (317) 879-1881.

CME Hours

20 Category 1-A

Fees

Prior to May 27, 1997

AAO Member	\$510.00
AAO Non-member	\$560.00
Residents/Interns	\$250.00

After May 27, 1997

AAO Member	\$610.00
AAO Non-member	\$660.00
Residents/Interns	\$350.00

The Textbook, "Osteopathic Considerations in Systemic Dysfunction will be available on site. \$40.00

Refund Policy

The American Academy of Osteopathy reserves the right to cancel this educational program if insufficient physicians pre-register. Sufficient registrations must be received 30 days prior to the opening of the course. If you are considering registering for this course less than 30 days prior to the opening, contact the Academy office before making travel plans. In the event of course cancellation by the Academy due to lack of registration, all money will be refunded.

Cancellation from participants received in writing for other reasons up to 30 days prior to the course opening are subject to withholding of a 15 percent administrative fee. All other cancellations will receive no refund but may transfer 80 percent of the tuition to another AAO educational program held within the next 12 months.

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actually speak otherwise. An analysis done by the American Osteopathic Board of Internal Medicine, of medicine subspecialty board scores of DOs who trained in allopathic residencies and fellowships from 1984 to 1992, versus the board scores of DOs who trained in osteopathic programs, during the same period, showed no significant difference (average 78.3 vs. 77.4).¹¹

Approximately half (in the senior class, slightly more than half) of the students felt that AOA residencies should stress OPP (#24). Some of the upperclassmen commented that with a dearth of AOA residencies stressing OPP, they had no motivation to seek out osteopathic residencies and based their selection criteria on perceived quality alone.

Overall less than a third (30 percent), of the students felt that there should be a required OMM rotation in the third or fourth year (#25). The percentages were fairly consistent across classes. The percentages of those who were emphatically against it were quite significant. Most students felt that only *optional* OMM rotations should be offered (which are).

The kicker, was the response to "whether students believed that the osteopathic profession should be more distinct from the allopathic profession," (#26) with only 23 percent responded positively. One student commented that distinctiveness for its own sake was pointless, "unless we are superior." A number of students commented that we are distinct enough. Some students even outright called for amalgamation with the MDs(!). There appears to be an attitude problem here, of the professions' making (by failing to provide a sufficiently strong and focused ideological education).

It was a bit surprising to note that the majority (67 percent), of upperclassmen (who were the only ones given the last

four statements) responded that they had used OMT, etc. on rotations (#27). More were positive in the senior class (75 percent), versus the juniors (57 percent), and across the board, more were mildly agreeing than strongly. However, the majority of students (64 percent), denied being encouraged, monitored or guided by staff DOs in the use of OMT (#28). Even many of the minority, who responded positively that they were encouraged by staff DOs, qualified their responses by saying that they have yet to see a DO attending or resident use OMT on a patient in the hospital. Their comments indicate that it was all lip service from the staff DOs.

As to "whether their use of OMT had been discouraged or disparaged by MDs, allopathic medical students or their own classmates" (#29), the minority (18 percent of the juniors, 21 percent of the seniors) who responded positively said it was not the MDs or allopathic medical students, but the DOs who discouraged the use of OMT! Many students commented that the MDs, and even more so the allopathic medical students, were mildly curious, interested, or even fascinated with the use of OMT. Some students wrote that some of their fellow osteopathic students mocked and ridiculed their use of OMT, while some allopathic students and MDs were requesting their services. In some hospitals the DOs regularly indicated on admission orders or notes "OMT not indicated" or "patient does not desire OMT." Of particularly dubious distinction is the surgery department in a certain exclusively AOA accredited hospital, where several students reported being told not to use OMT on pre and postoperative patients.

Finally only a small minority of 11 percent said that they are ashamed to use OMT in the hospital in front of others. Most of these attributed their reluctance to their lack of confidence in their manipulative skills.

Commentary

The cup can be viewed as being half empty or half full. Considering that this school (and probably most other Colleges of Osteopathic Medicine) has as a majority of its student body, students who wanted to be MDs, there has definitely been progress. The fact that a majority of students profess a belief in osteopathic principles and the effectiveness of OMT, and even the significant number that says that they'll use OMT, indicates that the school has had a positive impact on the students.

Yet, on careful examination one must conclude that the educational system has not done its job completely nor effectively. Considering the number of students who disassociate themselves from A. T. Still, and the large number of students who don't want the profession to be more distinctive from allopathy, I would say that the osteopathy of these students is in jeopardy. Let us not delude ourselves that the events in California of 1961 were a long time ago, and that this could not happen again, here and now in this day and age. All that it would take, is for the allopathic powers that be, to get it into their heads, to again offer MD degrees to any DO that is willing to exchange his or her degree. All less than stalwart DOs, such as the students whose osteopathic commitment is ambiguous as those mentioned above, would jump at the opportunity; and there is *nothing* that the schools nor the AOA could do to stanch the hemorrhage. It happened once before in one state, it could happen again nationally, since some thirty years later the allopathic establishment accepts us much more as equal clinicians, and would be far more amenable to amalgamation than ever before. If such an event were to be witnessed by the federal and state governments, it would send to them a powerful message of our redundancy as a separate profession.¹ It will be us who did it to ourselves,

victims of our own success. We can't even blame the MDs, for we've demonstrated to them that we're the same. Ask most young MDs or allopathic medical students who have been exposed to us, what the difference is between a DO and an MD, and they'll shrug their shoulders and answer, "I dunno."

Decisive measures must be taken. As Dr. Gevitz stated "osteopathic medicine must rhetorically and politically move beyond the stage of emphasizing and demonstrating that DOs are just as qualified, just as good, and are equal to MDs. That struggle has essentially been won. To continue hammering on this point... is simply pounding sand."¹² He further writes that it is more important that a lesser quantity of osteopathic students receive a "distinctive, continuous, and meaningful" osteopathic education on both under graduate and GME arenas, than to educate larger quantities of less dedicated DO students whose "distinctive osteopathic medical education is too brief (and anything less than four years plus the GME years is too brief), without enduring value; students who will conclude (and many do) that an independent osteopathic medical profession is "vestigial and unnecessary."¹²

Dr. Meyer seems to believe that osteopathic medicine is a "game." It is only as of his recent writings that he has stopped hammering on confining us in primary care, and focused on hospitals making quality changes to attract DO residents.¹³ He, apparently, is missing the point even with all the positive changes he has suggested including the emphasizing of OPP. His focus appears to be for the purpose of keeping alive osteopathic hospitals and the osteopathic profession for the sake of its own existence, not because we *are* different and we *do* something different. It is

shocking that to Dr. Meyer *it is a question* (!) whether it is "worth it to keep our separate pathway."¹ Dr. Meyer's response to the COMP student's (John Wogec, MSIV) letter to the editor, still misses the point, with his insistence on characterizing students who subsequently take allopathic residencies as having "left" the profession.¹⁴ The student has not *left* the profession, because if the osteopathic hospitals are not utilizing OPP, then there *is nothing* to have left. Disloyal? To what? An "old boys" network that themselves have been disloyal to their profession and their founder. The student may actually be proving him/herself to be *more loyal* by demonstrating that he/she refuses to participate in this charade of calling *non-osteopathic* osteopathic hospitals and residencies "different."

Michael Ward, a senior at KCOM, stated it well when he wrote "Because the profession has failed to maximize the difference osteopathic manipulative treatment can make, factors such as salary, location and prestige have become overridingly important to students when selecting GME programs." Mr. Ward continues, rightfully lamenting the fact that we are given mixed messages from school to hospital.¹⁵

It is difficult to shed alligator tears for failing osteopathic hospitals, if there is nothing osteopathic about them, other than their accreditation and staff roster. If they fail to promote OPP, then *what's* different about them? A home for DOs? An osteopathic label? Let us not cheapen and trivialize the purpose of osteopathic hospitals.

Dr. Ross-Lee is concerned that we are having a decline of students entering generalist fields, and of our need to get aggressive in promoting osteopathic primary care GME.⁵ I feel that if we can maintain our status quo in primary care percentages, or perhaps a slight increase,

then we will be doing just fine in that regard. What is dismaying is that one of our leading spokespersons, Dr. Ross-Lee, fails to mention one word about OPP in any of her writings (at least any that I have read), not one peep!

I don't mean to knock an emphasis on primary care, after all it *is* a strength of our profession, and meshes well with our profession, since we *are* holistic physicians. It is true, that a much more significant percentage of DOs have chosen and are choosing primary care than MDs, but if the powers of health care reform have anything to say about it, or the market forces of managed care, then that will change significantly. Then, what will be our claim to fame?

It is important that we continue to produce a high percentage of primary care physicians, but one can also utilize OPP in virtually any specialty that one chooses, be it psychiatry, neurology, obstetrics/gynecology, orthopedic surgery, and others. OPP can be useful in all of these and other specialties, and it is important that OPP be available to patients in these specialties.

One might ask what can be *osteopathic* about a radiologist or a pathologist? I will answer, the same thing that is *medical* about them. In the event that an osteopathic radiologist or pathologist (who after all, *is* a physician) would happen to treat a patient (not an unlikely scenario), before he or she will whip out their prescription pad, they will view their patient osteopathically and consider using OMT.

The West Virginia School of Osteopathic Medicine (WVSOM) has made a good start, but it is important not to skimp. When James R. Stookey, DO, vice president for academic affairs and dean, convened his committee for integrating OPP into WVSOM's entire undergraduate curriculum, he told them that "their proposals could not require an increase in faculty, money, or OPP

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j) In this era of cost cutting, neither the governments, nor Health Maintenance Organizations (HMOs) are likely to tolerate redundancy.

course time.”¹⁶ I appreciate the fact that a state supported osteopathic school might be kept on a shoestring budget by the state, and perhaps even be only tolerated by the state only because of its significant contribution to filling a primary care need (as compared to a more popular and heavily supported allopathic state supported institutions). Be forewarned that if the forces of health care reform will have their way, or market forces provide less career opportunities for specialists, those state supported allopathic institutions will be contributing significantly more to the state’s primary care needs, *then* watch state support for the osteopathic school dry up if it hasn’t demonstrated its uniqueness. It should be noted that in a study released by the Association of American Medical Colleges, a whopping 42 percent of West Virginia’s Marshall University School of Medicine’s graduates, from between 1984 to 1994, went into primary care fields of internal medicine, family practice, and general pediatrics.¹⁷ Thus, even the state supported schools are going to have to get creative in their fund raising in order to increase the osteopathic contents of their curriculum now. Noteworthy at this point is WVSOM’s own survey of its class of 1997, which had some similar results and some different results. One result that I wish to point out is their positive response rate of 49 percent regarding whether “the osteopathic medical profession needs to remain distinct from the allopathic medical profession,”¹⁸ compared to a positive response of only 23 percent on this survey. I will note that WVSOM, which is a small rural school, many of whose students are the children of rural DOs or were exposed to rural DOs, also had a positive response of *less* than 50 percent to the above mentioned statement.

The recommendations made at the fifth GME leadership conference¹ are

good but they are not enough. We need more drastic changes, for these are dangerous times.

For starters, we need more indoctrination and instillation of a sense of identity and belonging. The one hour each lecture in osteopathic/medical history and osteopathic philosophy is paltry. Students should be taught a full semester course each in both osteopathic history and osteopathic philosophy, with required readings from the works of A. T. Still. So students shouldn’t feel that they can bluff their way through a philosophy course, each student should be required to write an essay and pass an oral examination. When this alone is implemented, we will start to see some drastic changes in the percentages of dedicated DOs that we put out.

The AOA *must* require the colleges to increase their OMM faculty. The students are not getting enough attention. Students need to have a considerable amount of clinical time in their first and second years treating real patients.

The AOA must mount an aggressive public awareness campaign, so that everybody knows who a DO is and what he/she does. Nobody is ambiguous about what a chiropractor does. The main reason the public doesn’t know what it is that DOs do is because most of us don’t seem to know ourselves. We’ve been trying for so many years to look like MDs that few can tell the difference. In all fairness, perhaps there was good purpose in straying from our practices in order to obtain the equality we needed with MDs, but now that this has basically been accomplished, it’s time to come home, to return to our roots.

Then there is osteopathic manipulation in the cranial field, that much maligned and misunderstood jewel of OMT. The way it is taught at NYCOM (and probably most other schools), it is a wonder that everybody doesn’t think it is voodoo. We can’t learn

it nor even appreciate it with the scant hours and few instructors that they give us. If it was not for the fact that as a patient I had experienced the wonders of cranial manipulation, I too would think that it is bunk. It is a disgrace to the profession that, if a student wants to *really* learn cranial, then they must spend up to a \$1000 (plus airfare, hotel, and transport) to take one of the few forty hour cranial courses that are offered around the country in the summer. I have yet to meet anyone who has been to one of these cranial courses that wasn’t able to learn the basics of cranial manipulation, and thinks that it’s hocus pocus. The schools should integrate into their curriculum a full fledged cranial manipulation course that’s properly staffed.

The AOA should mandate third and fourth year OMM hospital rotations. If the incoming students have been well indoctrinated and trained in their first two years, then they will not object.

The AOA should definitely continue emphasizing, and even requiring, rotating internships. What many students dismiss as “another year of scut”, is an opportunity to become well rounded as a physician, regardless of future specialty. This is important not just as a DO, but as a physician. Several prominent MDs have emphasized to me the importance of doing a rotating internship, stating that one must become a doctor before one can become a specialist. Needless to say, OPP must be stressed in internships, as well as AOA residencies.

Stanley Schiowitz, DO, FAAO, the academic dean here at NYCOM, wrote of the difficulty of integrating OPP and of the time constraints.¹⁹ Perhaps the AOA needs to seriously consider whether a four year curriculum is enough. Perhaps it might justifiably make a four and a half to five year curriculum to provide the proper undergraduate education of a DO.¹ Lets

face it, we need more training, not less than the MDs, because we *are* more (or at least we're supposed to be). As it is, prospective students are banging down our doors to get into school. I do not accept the argument that the changes we would make are going to empty our class seats. We need educational integrity.

We need basic science professors who will integrate OPP into their material. Dr. Schiowitz said that a school cannot mandate integration of OPP by edict.¹⁹ Dr. Schiowitz has more experience than me, but still, I beg to respectfully differ. First one tries with candy (money), when that fails, use a whip (their jobs). There are plenty of hungry and talented basic scientists out there. One just has to sweeten the pot.

In the hospitals, the AOA and the schools must require staff DOs with academic appointments (\$\$\$) to not only teach OPP, but to use it on patients and be a positive role model for our students. No more lip service. The schools need to hire full time faculty, whose job it is to monitor the teaching staffs' use and skills in OMT. If teaching staff DOs are reluctant to use OMT because their own skills are rusty from years of disuse, then the school faculty must provide remedial instruction for them. We need to get all of our DO hospital instructors up to speed, and with the program. Any staff DO who refuses to act like a DO should then subsequently be banned from training our students. There are plenty of excellent MDs out there. It is far better that an MD, who is not expected to manipulate, trains our students than a non-manipulating DO, who will set a poor example. If this all sounds draconian, then consider that non-survival as a profession should sound even more draconian. This all costs money, but so does almost everything else in life. The allopathic teaching

institutions seemed to be able to find the funding, so should the osteopathic be able to. I know it can't happen overnight, but Rome wasn't built in a day either. These changes will take time, but the time to start is now. It is time to get beyond just talk, and start some real action.

I don't think I can put it any better than Teresa A. Hubka, DO did when she wrote "If the philosophical foundation is laid in the early undergraduate years, further instilled and practiced in the clinical undergraduate years, and reinforced throughout graduate medical education, the decision for graduate training then becomes an issue of selecting the program that offers the most complete osteopathic medical education."²⁰ Furthermore, even if a DO does select allopathic graduate training, as Dr. Hubka said, "if you are strong in your beliefs as a DO, you seek osteopathic training in your spare time,"²⁰ and you will carry it where ever you go. For if not, as she said, our profession will "decay from within because of our lack of commitment to our art form, our lack of faith in our mission."²⁰ The key is that the initial foundation must be strong. It matters not that most of the students entered as "wannabe" MDs. All of these students are impressionable, and can be influenced and molded into proper DOs.

Philip E. Greenman, DO quotes Orren E. Smith, DO who watched the decline of the use of OMT and lamented almost half a century ago, "Who is to blame"? Dr. Greenman writes of the reforms we must make and says that "to do less denies the heritage of Andrew Taylor Still. Let us all become part of the solution, rather than part of the problem, so that 40 years hence another lecturer does not need to revisit 'who is to blame?' "²² I as a mere student, who

is in his osteopathic infancy, an innocent osteopathic babe, here and now, point my finger at you, the leadership of the AOA, and the conscience of osteopathy, the AAO. I say to you, that if you don't soon make the changes necessary to ensure our survival, then YOU will be to blame!^k

Conclusion

Although the osteopathic profession has made some progress in instilling an osteopathic belief in its students, the success is incomplete and the overall level of commitment is poor at best. Changes need to be made to ensure that we survive and thrive as a profession; but for what? Not for the sake of merely being an alternative to the allopathic profession. In my opinion, there are only three valid reasons for our continued existence as a separate profession: we are who we are, we believe what we believe, and we do what we do. Who are we? We are the disciples and heirs of the teachings and legacy of A. T. Still. What do we believe? We believe in the unifying integration and self regulation of the human body, and the primacy of the immune system in maintaining its health. We believe in the correlation of structure and function. We believe in the major role that the circulatory and nervous systems have in amplifying and moderating the immune system, and the pivotal role that the musculoskeletal system plays in their proper functioning. What is it that we do? We palpate and manipulate the musculoskeletal system to diagnose, restore, and maintain human health. These are the reasons for us to be a separate profession.

There are those who say that osteopathy has reached obsolescence. I say that the day that osteopathy is

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k) The question is: After reading this article, will you put it down and comment "nice paper", or will you be spurred to action on behalf of our profession?

obsolete is the day that MDs universally recognize and accept our principles. It is the day that throughout the allopathic world, Andrew Taylor Still, MD is recognized for the genius that he was, and his major contribution to medicine. That will be the day that MDs the world over, aside from using pharmaceuticals and technology, will also diagnose and heal with their hands and in effect themselves have become ten fingered osteopaths. On that day we will have come full circle, for thus was Dr. Still's original intent, when he approached Baker University to teach his concepts to MDs. When all of this comes to pass, perhaps then, I will consider exchanging my DO degree for an MD.

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On Great Danes, Labradors . . .

of a demon assigned to him by the Devil. The man spoke with God and received the answer to his question. The demon was distraught when telling Satan of his failure to keep the seeker from finding his knowledge. Satan responded "Do not worry, he is human. He will institutionalize it." I am afraid this is happening with the osteopathic philosophy. We have institutionalized the philosophy and now the institution is representing the philosophy less and less.

We began as radicals, we expanded as alternative, and we may fade as "mainstream." Our challenge of today is to remain – by remaining different. We tell ourselves that we are "as good as," "essentially the same" or "parallel" to our MD colleagues. If this is true – or if it became true – then someone's philosophical basis has shifted, and it is probably ours.

In linguistics there is a concept called "marked" and "unmarked." An unmarked item or concept is what one expects when a word is said. When I say the word "doctor," the general public envisions a white male. So, a Caucasian male physician is the standard, the expected, the "unmarked." All others identified by the word "physician" are "marked." They are outside of the general public's expectation for that group. Anything that is marked is noticed more easily, watched more closely. This can be a burden, especially if one wants to be in the unmarked group. Thus some Labradors became Great Danes and some DOs in California became MDs.

We are marked as osteopathic physicians. We are already different by our pedigree. In business everyone tries to find a "niche" to market. We already have one. We just need to dust it off and proudly display it. As Dr. Still said, "We must teach it, preach it and, practice it," if this profession is to survive. The "it" of which he was writing is the osteopathic **philosophy**. □

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"Myofascial Release"
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"Muscle Energy"
"High Velocity/Low Amplitude"
"Exercise"

FRIDAY, SEPTEMBER 19 (7:00 AM - 1:30 PM)

Breakfast Lecture Coding Update
"Thoracic Trouble-shooting"
(to include various modalities
approach - HVLA, ME, counterstrain,
indirect-MFR & cranial)
Skills Session: Thoracic
"Cervical/Suboccipital Troubleshooting"
Skills Session: Cervical/Suboccipital

SATURDAY, SEPTEMBER 20 (7:00 AM - 1:30 PM)

Breakfast Lecture Coding Update
"Lumbar/Pelvis Troubleshooting"
Skills Session: Lumbar/Pelvis
"Upper & Lower Extremities
Troubleshooting"
Skills Session: Extremities

SUNDAY, SEPTEMBER 21 (7:00 AM - 1:30 PM)

Breakfast Lecture - Coding Update
"Exercise"
Preparation for Manipulative Boards
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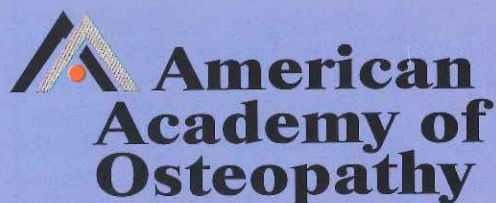
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