

THE AAO JOURNAL

 A Publication of the American Academy of Osteopathy

VOLUME 8 NUMBER 1 SPRING 1998



Recollections

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AAO's CME Calendar

American Academy of Osteopathy
3500 DePauw Boulevard, Suite 1080
Indianapolis, IN 46268-1136

Phone: (317) 879-1881 or FAX: (317)879-0563

March

23-25

*Visceral Manipulation
Manual Thermal Diagnosis*

John Glover, DO,
Program Chairperson
The Broadmoor Hotel
Colorado Springs, CO
Hours: 24 Category 1A

26-29

AAO Convocation
Dennis Dowling, DO, Program Chair
The Broadmoor Hotel
Colorado Springs, CO
Hours: 33 Category 1A

April

24-26

Exercise Prescription
Brad Sandler, DO, Program Chair
Denver, CO
Hours: 20 Category 1A

May

15-17

Functional Methods
William Johnston, DO, FAAO
Program Chairperson
Louisville, KY
Hours: 20 Category 1A

16-17

Advanced Percussion Vibrator
Richard Koss, DO, Program Chair
Louisville, KY
Hours: 15 Category 1A

June

12-14

Systemic Dysfunction
Michael Kuchera, DO, FAAO
Program Chairperson
Philadelphia, PA
Hours: 20 Category 1A

August

14-16

Levitor
Michael Kuchera, DO, FAAO
Program Chairperson
St. Paul, MN
Hours: 20 Category 1A

14-16

Visceral Manipulation
John Glover, DO, Program Chair
St. Paul, MN
Hours: 24 Category 1A

September

17-20

Fall OMT Update
Ann Habenicht, DO, FAAO,
Program Chairperson
The Coronado Springs Resort Hotel
Orlando, FL
Hours: 23 Category 1A

October

5-8

AOA/AAO Convention
Elaine Wallace, DO, Program Chair
New Orleans, LA

22-23

Introduction to OMT
John M. Jones, DO, Program Chair
Virginia Beach, VA
Hours: 16 Category 1A

24-25

Basic Muscle Energy
Walter Ehrenfeuchter, DO, FAAO
Program Chairperson
Virginia Beach, VA
Hours: 16 Category 1A

Affiliated Organization's CME Calendar

April 18-19

Cranial Nerve Entrapment Neuropathy
Richard A. Feely, DO, FAAO, Course Dir.
Holiday Inn O'Hare
Chicago, IL
Hours: 12 Category 1A
Contact: The Cranial Academy
(317) 594-0411

April 22-26

*1998 Palmetto Coast Regional
Osteopathic Scientific Conference*
Sponsored by South Carolina
Osteopathic Medical Association
Kiawah Island, SC
Hours: 25-30 Category 1A anticipated
Contact: Dawn K. Mirran
(800) 499-5751

April 30 - May 3, 1998

101st Annual Convention
Indiana Osteopathic Association
Radisson Hotel
Evansville, IN
Hours: 30 Category 1A
Contact: IAOP&S
(800) 942-0501

May 1-3

43rd Annual Conference
Florida Academy of Osteopathy and
Florida Osteopathic Foundation
The Plantation Inn and Golf Resort
Crystal River, FL
Hours: 19 Category 1A
Contact: For registration information:
FAO Office
(813) 545-3627

May 14-18

Basic Course: Osteopathy in the Cranial Field
Sutherland Cranial Teaching Foundation
UNTHSC-TCOM
Fort Worth, TX
Hours: 40 Category 1A
Contact: Judy Staser
(817) 735-2498

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American Academy of Osteopathy

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1997-1998

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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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An Official Publication

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Instructions for Authors

The American Academy of Osteopathy (AAO) Journal is a peer-reviewed publication 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

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 Osteopathic Manipulative Medicine, 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 three copies. 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.

6. For human or animal experimental investigations, include proof that the project was approved by an appropriate institutional review board, or when no such board is in place, that the manner in which informed consent was obtained from human subjects.

7. Describe the basic study design; define all statistical methods used; list measurement instruments, methods, and tools used for independent and dependent variables.

8. In the "Materials and Methods" section, identify all interventions that are used which do not comply with approved or standard usage.

Computer Disks

We encourage and welcome computer disks containing the material submitted in hard copy form. Though we prefer Macintosh 3-

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Provide a 150-word abstract that summarizes the main points of the paper and its conclusions.

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1. Be sure that illustrations submitted are clearly labeled.

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3. Include a caption for each figure.

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References

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

2. For journals, include the names of all authors, complete title of the article, name of the journal, volume number, date and inclusive page numbers. For books, include the name(s) of the editor(s), name and location of publisher and year of publication. Give page numbers for exact quotations.

Editorial Processing

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

From the Editor

by Raymond J. Hruby, DO, FAAO

Osteopathic Medicine: Recognized or not?

Let me begin by stating that I have been in a particularly (and perhaps peculiarly) feisty mood lately. In recent weeks I have been in several situations where I was concerned and sometimes frustrated about certain issues. I felt the need to speak out about these issues, to say what I felt was the truth about them. Needless to say, it is difficult to do this, especially when speaking truthfully means those who do not want to deal with the truth might be angry with me, and certainly might not like me very much for doing so. Nevertheless, sometimes you just have to take the bull by the horns and deal with difficult issues, no matter how painful it may be. Life sometimes deals us difficult situations, and the only way we can improve our world and ourselves is to face our demons and overcome them.

We take great pride in the fact that the osteopathic profession has achieved the status that it currently enjoys. We have all read or heard of stories about the struggle to gain full practice rights, one state at a time. We know how DOs came to be recognized as fully-licensed physicians by government agencies, the military and other organizations. We know how osteopathic physicians have gone from being discriminated against to becoming residents and attending physicians at some of the country's most prestigious allopathic institutions. Some DOs are even certified by allopathic specialty boards.

We should be proud of these accomplishments. At the same time, we should be concerned about the fact that in spite of these achievements we are still largely unrecognized by the

'organization' we serve — the general public. It is safe to say that if you stopped ten people on the street right now and asked them what a DO is, somewhere between nine and ten of those people would think you were from another planet. What is wrong here? We have achieved status as fully-licensed physicians equal to our allopathic counterparts, but we have not achieved recognition everywhere it is needed.

There are numerous examples of this lack of recognition. We all know about the problem that occurred several years ago when Congress passed part of the Omnibus Budget act and failed to list osteopathic physicians in the wording of this section of the bill. This meant that we would not be able to be paid by Medicaid for taking care of obstetrical patients or children who receive medical benefits under this program. It took several years of hard work by the AOA to rectify this situation. How much time, energy, and money could have been saved if such an oversight had not happened in the first place?

Another example: I was recently informed that I could join an on-line nationwide database of researchers so that I could be continuously updated about other researchers with similar interests, grant opportunities, and other such information. The on-line membership form contained several drop-down boxes to assist one in filling out the form. One box gave a listing of degrees from which to choose. The DO degree was not listed here. The form also asked me for a list of professional organizations to which I belong. Another drop-down box contained a long list of organizations

for me to select. Not one osteopathic organization was mentioned here.

Today I read two articles in my local newspaper: one article was about the 1918-1919 flu epidemic, and the other was about therapeutic touch. Neither of these articles made any mention of DOs or osteopathic medicine.

I could go on, but I think you get the picture. So what can we do about this situation? Several years ago in this column, I urged readers to think seriously about whether they were really prepared to talk to people about the osteopathic profession. Can you give a brief and understandable answer to someone when they ask you what a DO is, or what osteopathic medicine is? If not, you should prepare answers to these questions, even if you have to sit down, think them through, and write them out for yourself.

I have heard disgruntled DOs complain that the AOA should "do something to promote the profession." Information from the AOA often states that it is the individual osteopathic physician in his or her daily practice that promotes the osteopathic profession to the public. The logical answer is that both the national organization and its individual members need to work together to promote ourselves.

I have no magic bullet here. All I know is that achieving status as fully-licensed physicians is one thing, but gaining recognition of that status in the world is a different thing altogether. It is time we all pull together as a profession to work toward this recognition. □

Message from the President

by Ann L. Habenicht, DO, FAAO



An issue too great to ignore!

Greetings,

This will be my final message to you. My year as president of the Academy has moved quickly and has been a challenge. I thank you all for allowing me the opportunity to represent you as Academy President.

I recently returned from the winter American Osteopathic Association's (AOA) Board of Trustees' meeting. A specific action by the Board took place of which you need to be apprised. The resolution which was *disapproved* concerns any currently certified AAO member and/or any member who desires to become certified in OMM. First, some background information is needed.

As I stated in a previous message, there is still a considerable amount of confusion regarding American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine (AOBSPOMM). Because of the "SP" or *special proficiency* in the name, some members of our profession still believe that the C-SPOMM earned is a *certificate of added qualification* or CAQ. Remember, a CAQ is demonstration of further knowledge in a specific area such as geriatrics, adolescent medicine and sports medicine. One must be *certified* by a primary board before sitting for a CAQ exam. Various primary boards within the AOA include the internists, pediatricians, PM&R, ER, FPs, and OMM! These primary boards are VOTING members of the AOA's Bureau of Specialists or the certifying boards of the AOA.

This year, the members of AOBSPOMM (a certifying board of the AOA) decided to petition to change the name of the board due to the continued confusion. The recommended name as AOBMM or the American Osteopathic Board of Manipulative Medicine. This was chosen to rid the name of the confusion. Additionally, AOBOMM was not chosen due to the redundancy of having Osteopathic twice in the name (American Osteopathic Board of Osteopathic Manipulative Medicine). The resolution was sent to the Bureau of Specialists in January, 1998. After explanations to the Bureau, a unanimous vote was made to approve and recommend the change to the AOA BOT.

The resolution for the name change was referred to a

Board committee prior to a vote by the entire Board. This committee, the Committee on Basic Documents of Affiliated Organizations, did **NOT** recommend the name change. The explanation by the chairperson, Dr. Darryl Beehler, was that the committee did not have enough information. Upon hearing this, Dr. Tettambel, the chairperson of AOBSPOMM, identified herself and offered to answer any questions concerning AOBSPOMM. The Board offered no questions and voted to **NOT** allow the name change.

This action by the Committee on Basic Documents was quite puzzling. The "reason" for the denial was that the Committee was confused as to the status of AOBSPOMM, whether it is a **TRUE** certifying board or merely a CAQ. Documents demonstrating that AOBSPOMM is a certifying board, including the listing of AOBSPOMM in the Bureau's handbook's list of certifying boards and the dates they became boards (AOBSPOMM in 1977) – previously the board of fellowship) and the fact the only VOTING members of the Bureau are certifying boards (sports medicine is a non-voting member), failed to alleviate the Committee's concern.

The **INACTION** of this committee further demonstrates the need to have the name change take place! Not until the "SP" is out of the certifying board's name will this confusion end. There is also the fear that by having the name changed that DOs not certified by AOBMM would not receive reimbursement by managed care entities. The answer to alleviate this fear is two fold:

1. OMT is a procedure taught to all DOs. As such, it should be reimbursed to all DOs just as cerumen extraction, PAP smears, NG tube placement, application of splints, etc. are in the domain of DO's training.
2. Any attempt by a managed care entity not to pay a DO for OMT in lieu of an OMM certified DO should be fought with the same vigor that the AOA takes to prevent discrimination in reimbursement for treatment of CHF, pneumonia, ear pain, etc. by a non "specialist."

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Message from the Executive Director

by Stephen J. Noone, CAE



What distinguishes osteopathic medical practice?

The AOA Board of Trustees conducted a leadership conference in conjunction with their mid-year meeting. In addition to the Trustees and AOA senior staff members, participants included elected leaders and executive directors of virtually all AOA-affiliated organizations. Norman Gevitz, PhD delivered a provocative address in which he offered a series of proposals and recommendations to advance the public recognition of the osteopathic medical profession. As part of his presentation, Dr. Gevitz offered the following definition of osteopathic medicine:

“Osteopathic medicine is a complete and distinctive, primary care-centered approach to medical, surgical, and other health services, founded on a philosophy embracing the importance of hands-on evaluation and treatment of the total person, and dedicated to the furtherance of health care for all Americans, particularly under-served populations.”

AOA President Howard Levine arranged for various Trustees to be distributed in discussion groups the next day with leaders from state associations, practice affiliates and non-practice affiliates. The objective was to react to Dr. Gevitz’ presentation and brainstorm recommended action-oriented resolutions addressing the challenges presented.

Throughout the discussion, several participants in the practice affiliate group emphasized that “osteopathic medicine is not just osteopathic manipulative treatment, but rather a unique philosophical approach to the treatment of patients.” The dominant view was that Dr. Gevitz definition was too long, too complicated, etc. However, when pressed to define in more concise terms this “unique philosophical approach to the treatment of patients,” there was no consensus.

Personally, I have never heard any of the Academy’s leaders suggest that osteopathic medicine equals OMT.

Rather, they consistently emphasize both the basic philosophy and principles, and how OMT is an integral, unique component of osteopathic practice. Consider the Academy’s Mission Statement:

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

I maintain that the osteopathic profession should aggressively highlight OMT as *THE* distinguishing component of osteopathic medical practice and promote how the integration of palpatory diagnosis and manipulative techniques expresses the unique osteopathic philosophy and basic principles. In fact, in many instances, that is exactly what many AOA-affiliated organizations already do when they want to promote their distinctiveness. Take note of the photographs which accompany articles in the profession’s periodicals and newsletters detailing proceedings of many osteopathic conventions and seminars. You likely will find pictures of osteopathic physicians demonstrating various osteopathic manipulative treatment techniques to their colleagues. For example in *The DO* magazine: January 1998 - NOM Week article in Newsbriefs and two articles on North Carolina convention; October 1997 - OD&TS at the House of Delegates meeting; and July 1997 - article on Indiana convention.

In my opinion, by emphasizing the physical dimensions of osteopathic medical practice, the public would have a much clearer visual image of the distinctiveness of this profession, and would better understand the ensuing dialogue and explanations of the philosophy and basic principles. This emphasis would also serve as a catalyst throughout the profession to encourage all DOs to better integrate these unique dimensions in their own practices. □

Letter to A.T. Still

Dear Doctor Still,

I often wonder what you must have known about what we call the craniosacral system. While you never referred to such a system with this terminology, you must have known a great deal about it. I recall, for example, how you stated in your book, *Philosophy of Osteopathy* (p.39), "...the cerebrospinal fluid is the highest known element that is contained in the human body, and unless the brain furnishes this fluid in abundance a disabled condition of the body will remain. He who is able to reason will see that this great river of life must be tapped and the withering field irrigated at once, or the harvest of health be forever lost." These are powerful words, indicating that the

cerebrospinal fluid is important to the health of the human body in more ways than we know.

As you know, your student, William Garner Sutherland, DO, developed our best model of the craniosacral system, and developed successful therapeutic techniques to address structural problems in this system. I am sure the two of you must have talked about this subject while Dr. Sutherland was a student of yours at the American School of Osteopathy. Sutherland placed a great deal of importance on the cerebrospinal fluid. He developed what we refer to as osteopathy in the cranial field, and the healing power of the fluctuating cerebrospinal fluid was a most important element in Sutherland's system of diagnosis and treatment. He often re-

ferred to the 'potency' of the fluid, and developed techniques for harnessing this potency to treat his patients.

To this day, scientists still do not understand the full nature of the cerebrospinal fluid. Perhaps one day we will know everything there is to know about this mysterious substance. In the meantime, we do know that we can do wonderful things to help our patients by applying your osteopathic principles to the cranial area, and making use of the diagnostic and treatment techniques given to us by yourself and Dr. Sutherland. To say the least, we are deeply indebted to both of you.

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

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Science
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of Tomorrow

April 13-17, 1998

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Dr. Still's Grasp of Truth

From: History of Osteopathy and Twentieth Century Medical Practice
E.R. Booth, Cincinnati: The press of Jennings and Graham, 1905, pp. 63-65

Dr. Still fears mental stagnation more than "the plague." He believes in progress and constantly preaches the doctrine to his followers. He believes there is much in the osteopathy of the future that he has not fathomed. In 1896, he said:

"Osteopathy is a science; not what we know of it, but the subject we are studying, is as deep as eternity. We know but little of it. I have worked and worried here in Kirksville for twenty-two long years, and I intend to study for twenty-three thousand years yet."

Those who know Dr. Still know that he will not cease to be an original investigator so long as he lives. He often likened Osteopathy to a squirrel in a hole in a tree. He would say that he had succeeded in getting the tail out, and it was necessary for others to extricate the body from its hiding place. He believed that osteopathy is synonymous with truth, and it would gradually unfold and develop into perfect symmetry. This was what gave him courage to carry on his work under the most adverse and trying conditions. Singly and alone he went forward with his mind set upon the high ideal conceived within his own consciousness.

Dr. Still had no resentment for those that did not accept his views. He did not want pity; but he often pitied those who could not or would not see the truth. He did not ask for sympathy; but he always appreciated

the oneness of thought and feeling which comes from a knowledge of truth which seemed to be hidden from most men. He has often said he has had more fun because of the attitude of others towards his work, than any monkey ever had. He knew that he was right, and had an unswerving confidence that the right would prevail. The following quotation shows the spirit in which he worked:

"Osteopathy was a single fight. It was a fight for truth. It never struck a wave that made it tremble. When people would call me a crank I didn't get mad at that, I did not get cross at all. Said I, if you had as much sense on this subject as the sheep I would feel hard towards you, but you are perfectly excusable. I would ask the very fellows who laughed at me how many bones they had in their foot, and 75 percent of them could not tell. Each of those bones in the foot has a place to supply, muscles are attached to them, arteries and nerves pass around and between them."

The Name Osteopathy

Many criticisms have been offered as to the appropriateness of the term osteopathy to designate a system of medical practice, in its broad sense. No one word has been found that would more aptly express the ideas involved in the principles and practices of the science. The term was never used in the sense of a diseased bone, neither was it employed to indicate a bone-setting treatment.

The following explanation of the origin of the name osteopathy is given by Dr. Still in the catalogue of the American School of Osteopathy for 1902-3:

"I had worked and tried to reason that a body that was perfectly normal in structure could keep a man in the full enjoyment of health just as long as the body was perfectly normal. On that conclusion, I worked first to know what was normal in form and what was not normal; then I compared the two in disease and health. I found by hard study and experimenting that no human body was normal in bone form whilst harboring any disease, either acute or chronic. I got good results in adjusting these bodies to such a degree that people began to ask what I was going to call my new science."

"I listened to all who thought I ought to name my science, so I began to think over names, such as Allopathy, Hydropathy, Homoeopathy, and other names, and as I was in Kansas when the name Osawatomie was coined, by taking the first of the word Osage, and the last part of Pottawattamie, and the new word coined represented two tribes of Indians. I concluded I would start out with the word os (bone) and the word pathology, and press then into one word - Osteopathy."

"I wanted to call my science Osteopathy, and I did not care what Greek scholars said about it." □

Exercise Prescription for Manipulative Medicine

April 24-26, 1998

Denver, CO

Featuring
Philip E. Greenman, DO, FAAO

Program Chairperson and Instructor:

Brad S. Sandler, DO, CSPOMM

Special Guest Faculty:

Philip E. Greenman, DO, FAAO

CME Hours: 20 Category 1A
Pre-Registration Deadline:
April 1, 1998

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Educational objectives for AAO are to provide programs aimed to improve understanding of philosophy and diagnostic and manipulative skills of AAO members, DOs who are not AAO members, individuals who possess credentials required for unlimited licensure as physicians and for those in program leading to such license.

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American Academy of Osteopathy®
3500 DePauw Boulevard, Suite 1080
Indianapolis, Indiana 46268-1136
Phone: (317) 879-1881
Fax: (317) 879-0563

Program

April 24, 1998

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

April 25, 1998

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

April 26, 1998

Morning Session – 8:00 am

1. Sequencing home exercise programs and dosage
2. Reevaluation of partner and prescription of an individualized home exercise program
3. Closing questions and comments

Adjourn – 12:00 noon

Mail Registration Information

to:

AAO, 3500 DePauw Blvd., Suite 1080
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Refund Policy

The American Academy of Osteopathy reserves the right to cancel this educational program if insufficient physicians preregister. 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.

Sinusitis and OMT

by Karen Sept, DO

Identification:

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

Chief Complaint:

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

Past Medical History:

Negative.

Past Surgical History:

Negative.

Birth History:

No difficulties. Labor was six hours total.

Trauma History:

No motor vehicle accidents. He fell out of a tree landing on back just a few weeks ago. He had many injuries to the head which required suturing. He had had lacerations on his left eye, occiput, and twice on his chin which required sutures.

Medications:

None.

Allergies:

None.

Diet History:

Mother described him as a very picky eater for the last two years. He would not eat anything red in color. Breakfast: Kix cereal with milk. Mid-morning snack: Kix cereal with milk. Lunch: Often no lunch; occasionally soup or macaroni and cheese. Mid afternoon snack: Chex cereal with milk or jello. Dinner: Hot dogs with ketchup. Occasionally baked potato or cooked vegetable.

Physical Examination:

Weight 28.8 kilograms: Temperature 98.1 Fahrenheit: Pulse 78: Respiration 18: Well developed, well nourished 9-year-old white boy in no acute distress. He was very talkative, friendly, and cooperative. Physical exam was significant only for ENT exam. Tympanic membranes were pink and mobile. Inferior turbinates were red with purulent exudate. Face was non tender. Posterior oral pharynx was clear. Neck was supple and without lymph adenopathy. On structural examination in the standing position: Right ear was inferior, right shoulder and tip of the scapula were superior, right iliac crest was inferior, greater trochanters were equal. Lateral curvature was noted in the thoracic spine with a convexity right and apex at T8. His ear was noted to be anterior to the line of gravity. There was a notable flattening of the thoracic spine. Standing and seated flexion tests were positive on the right. In the supine position the pubic sym-

physis and anterior superior iliac spine were inferior on the right. In the prone position he was noted to have a left on left sacral torsion. The sacrum was markedly extended. On cranial exam his sphenobasilar symphysis was compressed. There was both an inferior vertical strain and a left torsion pattern.

Initial Assessment:

1. Somatic dysfunction all areas
2. Mild scoliosis. Consideration should be given to a short leg syndrome.
3. Chronic sinusitis by history
4. Migraine cephalalgia

Initial Treatment Plan:

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

ment, I would involve intraoral techniques for the face.

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

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

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

Course of Therapy:

As planned, the first treatment was aimed at normalizing the pelvis utilizing muscle energy techniques. At the conclusion of the first treatment, his ears were equal, the right shoulder was elevated, the tip of the scapulae were equal, the iliac crest heights were equal, and there was only a slight lateral curve with the convexity right still present in the thoracic spine. This improvement was still present at the next treatment. At the second treatment, I used the percussion hammer to his lower extremities, in addition to addressing the thoracic spine. The following visit he had symptoms of an upper respiratory infection with purulent exudate noted from the right nare. He was treated with osteopathic manipulation utilizing techniques to stimulate sinus drainage and encouraged to drink more fluids and use steam inhalation to thin the nasal secretions. This episode cleared without antibiotics and the following week his inferior turbinates were noted to be pink without swelling or purulent exudate. He had

one more episode of nasal congestion and cough approximately five weeks later. However, he had no fever or chills and had a good appetite. He said he did not feel sick. He had quit doing his exercises and sinus irrigations. His vitality was low. His thoracic inlet was quite restricted. Sinus x-rays were obtained because I suspected a sinusitis. The left maxillary sinus was indeed cloudy. After discussing all the options with his mother, we chose to institute measures to encourage sinus drainage without medications. I instructed them to follow up the following week, or sooner if his condition worsened. At that time he was much better. The treatment program was completed. He was encouraged to continue his home program of diet, exercises, and preventative sinus measures. He was seen in follow up six weeks later and had continued to do well.

Discussion:

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

*President's Message
continued from page 6*

OMT is a procedure taught to all DOs and, by virtue of their degree, DOs are qualified to use OMT. There will still be times when an osteopathic physician will need assistance in the treatment of a patient's musculoskeletal problem. This is when a "specialist" is needed . . . a person with more expertise to address the problem, an OMM certified osteopathic physician. I have used the analogy of the infectious disease specialist, cardiologist, and pediatrician in the past and it should be self evident that the need for an OMM specialist meets the same argument to have other specialists.

Another important aspect to a specialty area is research. A fair amount of cardiac research is done under the eye of the cardiologist. So too, for the OMM certified "specialist." In order to continue to demonstrate the benefit of OMT and the scientific basis of osteopathic medicine, dedicated researchers and specialists are needed.

I am tired of the certification confusion! We Academy members need to make our voice known to our AOA leaders that the time to end the confusion is **NOW!** I urge each of you to voice your opinion to our leadership and, specifically, those members of the AOA BOT who form the Committee on Basic Documents of Affiliate Organizations. These physicians are:

1. Darryl Beehler, DO, Chair
2. Martin Diamond, DO, V-Chair
3. Carlo DiMarco, DO
4. Gerald Robbins, DO
5. Phillip L. Shettle, DO
6. T. Eugene Zachary, DO, Advisor

Please contact these gentlemen at the AOA, 142 East Ontario Street, Chicago, IL 60611. Additionally, send a letter to our current AOA President, Howard Levine, DO, and the President-Elect Ronald Esper, DO. **This issue is too great to ignore!** □

Zink and Sinks

by Melainie Cameron B.App.Sc (Osteopathy)

As an Australian osteopath visiting the USA, I was asked many interesting and unusual questions about my homeland. A commonly occurring theme of transequatorial osteopathic conversations has been whether the reversed fluid dynamics in the Southern Hemisphere produce reverse compensatory patterns within the human frame.

Readers are no doubt familiar with the Common Compensatory Pattern (CCP) and its reverse, the Uncommon Compensatory Pattern (UCP), as first described by Zink¹. Although the interrater reliability of palpatory assessment of any structures other than bony prominences is notoriously poor, Zink, and many osteopaths since, reported detecting the CCP consistently and frequently.

There are many angles on the debate over CCP. Firstly, if the likelihood of two osteopaths agreeing on palpatory findings is poor, how do we know what we are feeling? Assuming we are indeed detecting fascial strain patterns, what causes such strain? Some suggest gravity, others suggest fluid dynamics.

Either may be responsible for fascial drag, but neither is likely to lead to the CCP in the Northern Hemisphere and the UCP in the Southern. Gravity is similar the world over, that is a pull towards the Earth, a constant force of almost 10 Newtons. If gravity were reversed in the Southern Hemisphere, we would fly Down Under, not stand on our heads or develop UCPs.

One of the more commonly known aspects of fluid dynamics in the Coriolis force, but contrary to popular belief, this force does not make water "go down the sink the opposite way in Australia." According to the Glossary of Weather and Climate, the Coriolis force acts relative to the Earth's surface, deflecting objects to the right in the Northern Hemisphere and to the left in the Southern Hemisphere due to the Earth's rotation.² Coriolis only exerts a statistically significant effect on large bodies of water, such as an ocean, but has no significant effect on small fluid bodies such as a bathtub. The R-value (Rossby number, represents statistical significance) of Coriolis force on a bathtub of water is approximately 1000. Only R-values of 0.5 or less may be considered statistically significant. To quote Australian meteorologist, Dr. Rachel Law, "I would

have thought human beings were mostly on the same scale as bathtubs, so unlikely that we are significantly effected by Coriolis."³

Another possible explanation of CCP is that some 80 percent of infants are positioned LOA at birth. Birthing positions appear to occur in the same frequencies both North and South of the equator.

References

1. Kuchera, WA, Kuchera, ML. (1991) Osteopathic principles in practice. Kirksville College of Osteopathic Medicine, Kirksville, MO.
2. Geer, IW. (1996) Glossary of weather and climate with related oceanic and hydrologic terms. American Meteorological Society, Boston, MA.
3. Law, RM. (1997) Personal correspondence.



A faculty position will be available July 1, 1998 in a progressive department of Osteopathic Principles and Practice. The College has recently completed extensive new facilities and is located in a beautiful Midwestern setting. The successful candidate will join a dynamic, growing department dedicated to innovative teaching, quality health care and scholarly activities. The candidate must be board certified or have residency training and be board eligible, preferably in osteopathic manipulative medicine or family medicine, eager to participate in teaching at both undergraduate and graduate levels and have excellent communications skills. The college environment provides excellent opportunities for professional growth. Salary and academic rank will be commensurate with experience. Please send your vita and letter of application along with 3 names and addresses for letters of references to:

Dawn M. Harrington
Director of Human Resources
University of Health Sciences
College of Osteopathic Medicine
1750 Independence Blvd.
Kansas City, MO 64106

All inquires will receive a written response and submitted information will be forwarded to Michael M. Patterson, Ph.D., Chair, Search Committee.

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Review of *Foundations for Osteopathic Medicine*

by Sherman Gorbis, DO, FAAO, Associate Professor, MSUCOM

Editor's Note: Two pages of this review were omitted in the December issue of the *JAAO* in error. Please find below Dr. Gorbis' review of *Foundations for Osteopathic Medicine* in its entirety.

In the late 1980s, Howard M. Levine, DO, FACFP, then chairperson of the American Osteopathic Association (AOA) Bureau of Research, issued a challenge that a textbook be developed for use of all osteopathic students and physicians. He felt that our students should learn to "think osteopathically" and should know when and how to use osteopathic principles and practice (OPP) and osteopathic manipulative treatment (OMT) in all clinical situations when appropriate. Within earshot of Dr. Levine's words, was Robert C. Ward, DO, FAAO. Dr. Ward became the Executive Editor of *Foundations for Osteopathic Medicine* (*Foundations*).

The text is divided into the following sections:

- I. Osteopathic Philosophy
- II. History
- III. Basic Sciences
- IV. Behavioral Sciences
- V. Clinical Problem Solving
- VI. Family Practice & Primary Care
- VII. Clinical Specialties
- VIII. Palpatory Diagnosis & Manipulative Treatment
- IX. Health Restoration
- X. Applications of Basic and Clinical Research for Osteopathic Theory & Practice

Sections I and II very nicely relate osteopathic philosophy and history. The principles of osteopathic philosophy include:

1. The body is a unit; the person is a unit of body, mind, and spirit.
2. The body is capable of self-regulation, self-healing, and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based upon a basic understanding of the principles of body unity, self-regulation, and the interrelationship of structure and function.

These principles are a common thread woven throughout the *Foundations* textbook. Section III provides a comprehensive description of principles of anatomy, physiology, and pharmacology, as well as regulatory mechanisms such as the autonomic nervous system, the neuroendocrine-immune system, and the neurophysiologic system. If osteopathic medical students have the opportunity to read these first three sections early in their first term, they would learn the building blocks upon which the principles of osteopathic philosophy are based. They would also understand the normal structure that the use of appropriate OMT hopes to attain, thereby allowing normal function to occur.

Section IV, *Osteopathic Considerations in the Behavioral Sciences*, clearly brings home the point that there is a patient involved in patient-care and the doctor-patient relation-

ship. As physicians, we deal with more than just patients who have diseases. This section very nicely describes variables that patients can address so that they may begin to take some responsibility for their health improvement. Inquiring about various aspects of a patient's life, and really caring about patients, are ideas that are mentioned many times throughout the text. Not coincidentally, these are areas that patients feel add to the distinctiveness of osteopathic physicians.

Section V, *Osteopathic Considerations in Clinical Problem Solving*, is a very solid presentation and can help students and physicians towards the goal of "thinking osteopathically."

The section concerning family practice and primary care continues the theme of looking at the whole patient and incorporating osteopathic principles. Section VII, *Osteopathic Considerations in the Clinical Specialties*, is especially informative. Dr. Ward should be commended for his choice of Felix J. Rogers, DO, FACOI, FACC, as section coordinator. Each chapter in the clinical specialties makes reference to osteopathic principles and the prudent use of OMT in the total care of patients in each specialty. The chapter on geriatrics, by Thomas A. Cavalieri, DO, provides a thorough description of the osteopathic approach to our senior citizens. Dr. Cavalieri states that, "Aging changes in the musculoskeletal system include a loss of muscle

mass and a decrease in bone mineral density. These effects on bone predispose the elderly to osteoporosis and fractures. This factor must be considered in the selection of certain osteopathic manipulative techniques in this age group." A somewhat parallel statement is made by Melicien A. Tettambel, DO, FAAO, FACOOG, in the chapter on obstetrics. Dr. Tettambel states, "The patient may be treated in the sitting, standing, prone, or supine position – whichever position she can best tolerate. Almost any type of treatment modality (both direct action or indirect method) can be used, depending on operator skill and patient acceptance." These authors make it clear that osteopathic physicians should be comfortable using more than one type of osteopathic manipulative treatment approach. That approach, of course, depends on what the patient allows the physician to perform. This concept is also nicely described in the oncology chapter, authored by Michael I. Opiari, DO.

The use of OMT in the patient who has undergone a coronary artery bypass graft is mentioned both in the cardiology chapter by Dr. Rogers and in the general surgery chapter, authored by Sydney P. Ross, DO, FACOS, Mitchell L. Elkiss, DO, FACN, and Louis E. Rentz, DO, the authors of the neurology chapter provide a very clear explanation of the concept of osteopathic lesion. (The term "osteopathic lesion" seems to be falling out of usage, being replaced by "somatic dysfunction," which, for the most part, has been used in *Foundations*.)

Our students would certainly have stimulus to "think osteopathically" if these chapters in the clinical specialties were required reading during their osteopathic medical college matriculation. The authors of these chapters make reference to many research studies that have been done in the past. They also, correctly, state that more research is needed in many

clinical specialties to prove the positive outcomes of osteopathic manipulative medicine in patient care.

Section VIII, Osteopathic Considerations in Palpatory Diagnosis and Manipulative Treatment, begins with palpatory skill exercises as well as barrier theories along with suggestions for musculoskeletal examination and treatment plan (Part A). The next part (B) of this section, Regional Examination and Treatment, is extremely interesting and valuable. The authors very carefully describe the innervation of various regions, including sympathetic and parasympathetic innervation, lymphatic supply, as well as arterial and venous supply. Karen M. Steele, DO, FAAO, makes reference to the importance of normalizing neurological control and improving arterial circulation as well as venous and lymphatic drainage during the treatment of hospitalized patients.

(Part C) Palpatory Diagnosis and Manipulative Treatment, is very comprehensive. It contains excellent descriptions of osteopathic manipulative medicine treatment modalities that are now taught in most osteopathic colleges. These techniques include high-velocity low-amplitude, muscle energy, articular, soft tissue, functional, strain and counterstrain, fascial-ligamentous release, facilitated positional release, integrated neuro-musculoskeletal release and myofascial release, cranial, myofascial trigger points, Chapman's reflexes and lymphatics. Even though there is not total consistency in the teaching of osteopathic diagnosis and treatment in our colleges, our students should at least understand, and locate, the direction of restriction and the direction of ease in a somatic dysfunction. I found it quite fascinating to read about the history of many of these techniques and how they evolved to their present state of usage. Students would be wise, even if

some of this material were not presented in their colleges, to read these chapters. Any questions that they might have, could be directed to the respective faculty in each college or to clinical preceptors practicing OMT. It was most enjoyable reading chapters written by mentors or contemporaries. Anyone who has learned from or with these fine physicians knows the passion that they bring to their clinical work as well as to their didactic teaching. This would certainly hold true for any of the authors in this text. One can find excellent functional anatomy descriptions of the pelvis and the sacrum, especially nutation and counter-nutation, in Chapter 49. There is an excellent description of sacral treatment objectives in Chapter 54 by John P. Goodridge, DO, FAAO, and William A. Kuchera, DO, FAAO. This should be read by any student or osteopathic physician considering using the biomechanical model for treatment. The discussion of the thoracoabdominal diaphragm along with the pelvic diaphragm is an excellent mechanism to bring in the importance of the respiratory/circulatory model in this chapter. Chapter 57, on functional technique by William L. Johnston, DO, FAAO, not only contains a fascinating history, but an excellent description of this technical but most effective type of treatment. Chapter 72, Postural Considerations in the Sagittal Plane, by Michael L. Kuchera, DO, FAAO, contains an excellent piece on spondylolisthesis, including osteopathic concepts. Chapter 73 discusses efficacy and complications of osteopathic manipulative treatment. If a physician prescribes a medication, she/he should be familiar with its side-effects and/or complications. The same should be said for OMT modalities. This chapter should be read not to strike fear into any student or practitioner but to enhance their respect for these powerful tech-

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niques. The learning of palpatory skills while in osteopathic college and beyond cannot be overemphasized. The ability to find areas of greatest restriction and to treat these areas with appropriate OMT is a skill that should continue to be enhanced throughout one's practice career. The *Foundation* text lays the groundwork and building blocks for the proper learning and application of appropriate OMT.

Section X, Applications of Basic and Clinical Research, is becoming more important on a daily basis in today's practice environment. Harry D. Friedman, DO, offers a sample of a medical record in clinical research. The use of a standardized format is something whose time has come. Chapter 84 offers suggestions on research models. It would certainly be appropriate to discuss these issues at the various osteopathic colleges bringing in multidisciplinary input from both basic sciences and clinicians.

Dr. Levine, after years of dedicated osteopathic practice, issued a challenge for the development of a textbook. Was his challenge met? Clearly, yes! Dr. Ward and his authors have produced a volume which should be required in every osteopathic college in the United States. Presently, 14 of our 19 colleges are using the *Foundations* text. Our students need to be exposed to our osteopathic uniqueness and distinctiveness during their application process, interview, and orientation. Basic scientists teaching in our colleges can use the *Foundations* text in their courses. The inclusion of readings from *Foundations* would immediately help make these basic science courses osteopathic, unique from basic science courses taught in allopathic colleges. Systems coordinators could use the *Foundations* text in their courses. References, when appropriate, can be cited to help primary care and clinical specialty courses become osteopathic, com-

pared to courses taught in allopathic colleges. OMM faculty should use the *Foundations* text to enhance what is presently being taught in these skills courses. By having the entire faculty use the *Foundations* text as a resource, our osteopathic students will always realize they are in an osteopathic college, not only when they are in OMM lab. There should be discussion and interaction between basic scientists and those clinicians teaching the specialties as well as clinical skills (including OMM).

Dr. Ward and his faculty accepted and met Dr. Levine's challenge. What they have also done is challenged the hospitals in which our students, interns, and residents receive their clinical training. The Osteopathic Post-Doctoral Training Institute (OPTI) model of postgraduate osteopathic medical education is now being developed. By using the *Foundations* text, every service through which our students, interns, and residents rotate, can be made osteopathic. "Thinking osteopathically" can now occur from the beginning of our osteopathic students' education through their postgraduate education, with the help of *Foundations for Osteopathic Medicine*. □

AAO
Annual Convocation
March 26-29, 1998
The Broadmoor Hotel
 in Colorado Springs

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 Call (719) 634-7711

 Travel arrangements made?
 Call (800) 274-5975

Affiliate CME Calendar
 continued from page 3

June 4-7

1998 Chesapeake Regional Osteopathic Scientific Conference
 Maryland Association of Osteopathic Physicians
 Princess Bayside Resort
 Ocean City, MD
 Hours: 25-30 Category 1A anticipated
 Contact: Dawn K. Mirran
 (800) 499-5751

June 25-28

Back to our Roots: Sutherland's Methods of Treating the Whole Body
 Theresa Cisler, DO, Course Director
 Wyndham Emerald Plaza
 San Diego, CA
 Hours: 21 Category 1A
 Contact: The Cranial Academy
 (317) 594-0411

July 24-26

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

August 21-23

Osteopathic Integration in Working with Complicated Patients with Disbiosis
 Indiana Academy of Osteopathy
 Indianapolis, IN
 Hours: 20 Hours Category 1A
 Contact: Michael Claphan, CAE
 (317) 926-3009

September 3-6

1998 Great Smoky Mountain Regional Osteopathic Scientific Conference
 North Carolina Osteopathic Medical Assn
 Grove Park Inn Resort
 Asheville, NC
 Hours: 25-30 Category 1A anticipated
 Contact: Dawn K. Mirran
 (800) 499-5751

November 6-8

The Face
 SCTF Intermediate Course
 Douglas Vick, DO, Program Director
 Eastmoreland Hospital
 Portland, OR
 Contact: Eastmoreland Hospital
 OMM Department
 (503) 230-2501

Winner of the 1997 A. Hollis Wolf Case Presentation reports on trip to Europe

by Stephen P. Cavanaugh, MS-II, UNTHSC/TCOM

Editor's Note: *Stephen Cavanaugh is currently a third-year student at Texas College of Osteopathic Medicine who is interested in specializing in osteopathic manipulative medicine.*

At the spring AAO convocation I gave a case presentation and was awarded an all expense paid trip to Europe by the European Register of Osteopaths. On this trip to Belgium and France, I was given tours of many cities and treated to meals every day at the finest restaurants in Europe. I also had an opportunity to learn about osteopathy in Europe.

Osteopathic Medicine in Europe

I will try to relate my thoughts on my experience of osteopathy in Europe. In 1874, Dr. Still discovered osteopathy, a philosophy based upon the body's ability to heal itself and our ability to interact with the body to facilitate healing. This philosophy and practice are very much alive among osteopaths in Europe today.

I had the pleasure of working with four osteopaths, attending a convention, being treated by the president of the French osteopaths, and discussing osteopathy with many DOs. I noticed that European osteopaths truly treat the body as a unit.

Dr. Debroux, the first doctor I prac-

ticed with focuses on the continuity of the fascia, working within this network to treat patients. In one of the treatments I saw, he treated the thoracics with high velocity. Then, he did myofascial treatment on the sacrum and abdomen, and, finally, treated the lumbosacral fascia and thigh fascia via external rotation of the thigh and eversion of the foot. I learned from him the importance of the continuity of the fascia from head to toe and observed his great success treating in this manner.

Dr. Fieww, who I next visited, emphasizes the importance of treating the viscera and working through mechanisms of mobility and motility to facilitate healing. He applied visceral techniques to problems like bladder prolapse. This led me to think about how A.T. Still set up a philosophy intended to treat patients with all illnesses, not only musculoskeletal problems, but also visceral and medical problems.

Dr. Van den Brande-Yung taught me how a complete osteopathic approach to a patient can be successful in treating a broad number of ailments including TMJ, ganglion cyst and some colon problems. She treats the whole musculoskeletal system on every patient, using a lot of springing, stretching, and soft tissue. She also addresses visceral problems, for example: breaking up colonic fibrosis.

Dr. Prunier, the last doctor I observed, treated a post-surgical breast cancer patient; myofascially treating the scar and treating related cervical radiculitis and rheumatism of the carpal-metacarpal joint. She emphasized that the most important element of osteopathy is understanding the link between the lesions and how they are related. What she said allowed me to think about patients and their problems in a more holistic manner.

The convention I attended focused on sciatica, disk herniation and low back pain. The presentations in the morning demonstrated an in depth study of anatomy, radiology, and medical as well as osteopathic problems. In the afternoon, I saw the school in Namur and learned from the two laboratory sessions. Dr. Colot, who was my host in Namur gave a presentation which involved treating in multiple planes and attaining a precise localization. I found this quite interesting especially since our training at TCOM emphasizes localization so much. His presentation extended localization to a higher level. I also enjoyed discussion with Dr. Dethier who told me about his methods for treating sciatica, which were quite interesting.

There were many osteopaths I spoke with on my trip. I talked with Dr. Engelem, president of Sutherland Cranial Teaching Foundation of Europe, who told me about her work

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with children with mental illnesses. This work is particularly fascinating to me, and I believe very important. She also told me that American osteopaths may now receive continuing medical education credit for classes taught by the SCTF. I hope this will allow American and European Osteopaths to share their ideas and work together for the advancement of the profession.

Dr. Mahin emphasized to me the importance of diagnosis; allowing the osteopath to treat the cause rather than the effect. This fit in well with my education, and has made me more aggressive in seeking a diagnosis in my treatment of patients.

Dr. Hamerlinck, president of the Belgian osteopaths discussed with me the politics of osteopathy and recognition in Belgium. I was pleased to learn that the European osteopaths are aggressively seeking full recognition by their governments. Dr. Kriwin discussed with me philosophy of osteopathy and the question "what is osteopathy?" He is president of the Belgian Academy of Osteopathy, who meets regularly to discuss the philosophy of osteopathy. Dr. Smis, president of the Flemish osteopaths, and Dr. Noelmans, president of the Sutherland Cranial Academy of Belgium, also offered insight into osteopathy and its role in European medicine. There were, of course, many other osteopaths I spoke with and learned from on my trip.

Dr. Andrieux, president of the French osteopaths, gave me an osteopathic treatment, as a gift, and so that I could learn his methods first-hand. He began with deep myofascial treatment of the abdomen after he located this central restriction via screening tests. Then, he reassessed and treated multiple other lesions including a cranial restriction, which much relieved my TMJ dysfunction. After the treatment I felt quite relaxed, and enjoyed improved health in the following months. Experiencing his method of treatment

broadened my perspective on how osteopathy may be used to treat patients with a variety of ailments.

A Guest in Europe

This was not by far merely an Academic trip! Throughout my trip I was treated like royalty. I was picked up at the airport by the president of the European osteopaths, Dr. Vandenshrick, who gave me a first hand tour of Brussels, and took me out to dinner with his wife. We enjoyed much conversation concerning osteopathy and I learned about the rigorous education of the European osteopaths. They study four years undergraduate in physical therapy and then part-time for four to six years in osteopathic philosophy, treatment, and medicine. I also learned that European osteopaths were located first in Britain, but now practice in Belgium, France, Germany, Switzerland, Greece, Italy, Luxembourg, Germany, and Portugal.

Then in Namur, my host, Dr. Calot showed me the medieval castle and its newly discovered Roman ruins and treated me to mussels and famous Belgian beer for lunch. In Charleroi, I enjoyed a peaceful walk deep in the woods with Dr. Debroux where we discussed osteopathy. Then, he took me to Binche where he taught me about their yearly festival celebrating the brotherhood of man. For the festival the men dress in a certain costume, called the gille, and parade downtown. This is a very unique celebration, and I was fascinated by its details, and I enjoyed walking the cobblestone streets of the town and visiting its brewery.

Then it was off to the northern part of Belgium which is Flemish speaking. Here I was guided on a tour of Gent by Dr. Hamerlinck, president of the Belgian osteopaths, and an expert on the history of this city. He showed me St. Bavo's Cathedral which has a blend of Romanesque, Gothic, and Baroque architecture. He also showed me the painting of the mystic lam, a

famous and beautiful piece of art; the medieval castle, located in the center of the city; the old port; and the palace. He told me about details a tourist never would have learned – that the entire old section of town still has canals under the roads. The next day we toured Brugge on foot and via boat, enjoying the Renaissance architecture from Brugge's many canals, and feasting on Belgian chocolate and coffee. Dr. Hamerlinck also treated me to Brugge's specialty, eel, which was quite good. And, finally, we enjoyed a Dali exhibit.

Soon, I headed off to Paris where Dr. Mahin took me to see the Louvre and the arc of triumph. The following day she took me to the top of the Eiffel Tower, then to a Gothic cathedral, at my request, and finally, to the old Latin Quarter of town and the beautiful Luxembourg park. We had dinner that night with the president of the French osteopaths at the oldest restaurant in Paris! In Paris, of course, I tried French escargot for the first time, which I found quite tasty.

My next hosts who are both osteopaths, Sabine and Florent Prunier, took me out to their beautiful home east of Paris, where I was treated to exquisite home cooked meals including chicken grilled with onion sauce and fondue. They also gave me many gifts including French wine and local honey which I have since enjoyed. No vacation would be complete without shopping in Paris, which is where they took me next, and I enjoyed walking the city with them and having lunch at a favorite Thai-Indonesian restaurant.

Well, there is much more to tell, but I am afraid I have already talked too long and still failed to do justice in describing the gracious gift I received, and the hospitality that was extended to me. At any rate, I extend my thanks to each and every one of the European osteopaths who shared with me their hospitality, and who were involved in making this trip possible. □

Application of osteopathic principles to a viral upper respiratory infection

by Stephen P. Cavanaugh, MS-II, UNTHSC/TCOM

History of Chief Complaint

The patient is a thirty-year-old male medical student who presents complaining of rhinorrhea, cough, and fatigue over a four-week period. The patient first developed rhinorrhea, which became yellow and bloody after a week. He also developed a nonproductive cough and throat pain, which has persisted to the present. He has remained afebrile, but in the past few days he has noticed facial edema. The patient has had upper respiratory infections in the past which have usually abated in two weeks. This infection, however has persisted.

Physical Exam

Physical exam shows an afebrile patient with bilateral edema of the cheeks, mucopurulent yellow discharge from the nose, an erythematous throat and left submandibular lymphadenopathy. Osteopathic structural exam revealed shoulder and iliac crest low on the right, bilateral paravertebral fullness in the mid thoracic region, and restriction at the left sacroiliac and the left middle ribs. Soft tissue scan revealed ropey, fibrotic tissue at the cervicothoracic junction, mid thoracic region, and lumbosacral junction. Segmental diagnosis revealed left innominate rotated posterior, a sacrum rotated left on a right oblique axis, lumbar verte-

bra four and five side bent right rotated left and backward bent, thoracic vertebra six and nine forward bent, and cervical vertebra two through six rotated right and side bent right. Sibson's fascia was tight on the left and the respiratory diaphragm was restricted bilaterally.

Initial Assessment

The patient is suffering an acute upper respiratory infection with accompanying musculoskeletal dysfunction of sacral, lumbar, thoracic and cervical regions.

Treatment Plan

First recommend increased fluid uptake and rest, and follow up with antibiotics if condition worsens. Second use osteopathic manipulative treatment to correct musculoskeletal dysfunction and to stimulate the immune system.

Course of Treatment

The patient was treated two times. The following is the first visit: a non-neutral sacrum was corrected using physiologic response. Then the pelvis, lumbar, thoracic, cervical and ribs were treated with direct muscle energy. After segmental dysfunctions were addressed I applied myofascial release to Sibson's fascia, and the respiratory diaphragm. Then lymphatic effleurage was applied to the face and

neck, followed by the lymphatic pump. Finally rib raising was done.

Patient follow up in two days demonstrated marked improvement: facial edema was totally gone, fatigue was eliminated, and rhinorrhea and cough were reduced significantly. In the follow up visit I applied fluid model a second time. Three days later the patient's cough persisted and he developed night sweats. We considered using antibiotics but decided to wait and see if the patient's condition worsened. In fact the patient began to improve significantly and his case resolved within the following week.

Discussion

This case demonstrates the application of neurologic, gravitational, and fluid models to a patient with a persistent upper respiratory infection. It illustrates the role of the Osteopath according to Dr. Still. He says and I quote: "The Osteopath removes the obstruction and lets the life giving current have full play, and man is restored to health."¹ What I did was remove obstruction using three basic models of Osteopathy.

Neurologic Model

The neurologic model was applied through the correction of structural somatic dysfunctions which contribute to hypersympathotonia and poten-

tially facilitate secondary bacterial infection. By eliminating somatic dysfunction in lumbar, thoracic and cervical regions, stimulation of the sympathetic chain ganglia and cervical ganglia is decreased, thus normalizing sympathetic tone throughout the body. Also rib raising was done to normalize sympathetic tone and facilitate lymphatic drainage.²

Gravitational Model

The gravitational model was utilized by application of treatment first to lower parts of the body, like the non-neutral sacrum, prior to treatment of the upper parts of the body, like the neutral cervicothoracic junction. This was done to minimize reversion of the upper body to a compensatory pattern, as well as to eliminate underlying stresses which tax the body's energy and lower its ability to heal.³

Fluid Model

Fluid model was applied to aid blood and lymphatic flow throughout the body, so that the body can overcome the infection. Specifically treating Sibson's fascia allows lymph to enter the venous system from the entire body. Then treating the respiratory diaphragm and ribs five, six and seven allows for better respiration and improved flow through the thoracic duct. After removing the obstruction, fluid movement was actually stimulated by applying lymphatic effleurage to the face and neck, and utilizing the lymphatic pump. Furthermore the fluid model was invoked when all other dysfunctions were treated because decreasing myofascial tension allows for better fluid flow through arteries, lymph, and nerves.⁴

Conclusion

This case demonstrates that relatively simple osteopathic techniques taught in the first year and a half of medical school are effective in treating not only musculoskeletal dysfunction, but also aid in treating general disease states, like upper respiratory infections. In doing so it provides a model of how Osteopathy can treat probably the most common ailment patients present with at a family medicine clinic.

Endnotes for case presentation

1. Webster, George V. DO, Sage Sayings of Still. Wetzel Publishing: CA. 1996. 83.
2. Kuchera, William and Michael. Osteopathic Principles in Practice. Greyden Press: Ohio. 1994. 65.
3. Kuchera, 45.
- 4 Kuchera, 81.□



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Letter to the Editor

Dear Ray,

Unfortunately, I will be unable to attend the AAO Convocation in Colorado Springs this March. High altitude seems to precipitate my atrial fibrillation. The scheduled program looks excellent. I wish I could be there to join the debate over the pelvis. I am very grateful to Dr. Nelson and the Academy for opening debate on this very important subject.

After reading Ken Nelson's article in the Winter 1997 *AAO Journal*, I feel a need to clarify Fred Mitchell, Sr.'s theoretical model of the pelvis, which I am aware, has for years been difficult for people to understand. I have labored with its concepts for all my professional life, and have found it necessary, for my own understanding, to make some minor modifications in the model. However, the basic model, formulated more than fifty years ago by Fred Mitchell, Sr., continues to demonstrate, for me, great predictive power diagnostically and therapeutically. My current modified theoretical model of the pelvis will be presented in detail, along with clinical applications, in *The Muscle Energy Manual*, Volume 3, slated for publication in mid-1998. I sincerely hope that my new book will clarify my father's concepts, as well as my own modifications of them.

Dr. Nelson's admitted confusion over the "...several terms which appear to overlap one another" can be attributed to the misapplication of terminology from one theoretical model to another, now superannuated, model. Dr. Nelson's paper can be viewed as the strongest possible defense of the Chicago (Fryette, Schwab, Beilke, and Strachan) pelvic model. In my view, the Chicago Model is an important part of history.

Beilke and Strachan were the teachers of both Fred Mitchell, Sr. and Jr., both Chicago alumni. Fred Mitchell, Sr.'s pelvic theories grew out of the Chicago Model he was taught.

Alumnus loyalty aside, I believe the Chicago Model of the pelvis should be replaced with the Mitchell Model (often inappropriately identified as The Muscle Energy Model), because of its greater clinical power.

Dr. Nelson's objection to diagnosis by positional asymmetry begins by misquoting me. The misquote, citing *The Muscle Energy Manual*, Volume 1, p. 21, reads: "There are sufficient variations within normal anatomy to invalidate the use of positional diagnosis alone." What was actually said on that page *recommended* diagnosis by positional asymmetry. Actual quote: "The symmetry or asymmetry of these landmarks is not determined by palpation **alone** (unless the examiner is visually impaired). The **visual** sense is much more reliable for making geometric judgments, especially if the examiner is trained in the disciplined use of eye dominance, visual fields, and visual parallax." Anatomic variations are addressed on the same page: "Occasionally the (sacral) hiatus commences as high as S3, or, in rare cases, is open the entire length of the sacrum. The two cornua are often different sizes, and this may mislead the examiner to believe a sacral positional fault exists." This was part of a warning not to use the cornua as measurement landmarks.

It distresses me considerably to have diagnosis by **positional** asymmetry dismissed in favor of palpating articular motion for diagnosis. After teaching manipulation to osteopathic students for almost 35 years, I

can state categorically that *validity* and *inter-rater reliability* of diagnosis by articular motion palpation is incredibly poor and does not improve much with practice. Whether the articular motion being palpated is induced actively or passively, the activity and changes in the soft tissues surrounding the joint are very difficult to ignore, and they do not accurately or reliably reflect the amount of movement occurring in the joint. Hypermobile joints are often surrounded by protective muscle guarding, which seems to be often misinterpreted as "motion restriction." Keep in mind that the joint became hypermobile before the spasm started, and the spasm developed to protect the joint. Even though the pelvic joints are passive (not crossed by muscles which move the bones of the joint), adjacent muscles can be reflexly involved in such reflex behavior.

I am in complete agreement with Dr. Nelson's 3 criteria regarding restriction of normal articular motion. But we do not agree on the appropriate method of diagnosing articular motion restriction. In advocating diagnosis by articular motion palpation, Dr. Nelson appears to disregard his own criterion: "(3) The definition of the mechanics of articular motion is best, whenever possible, delineated using reproducible technical methods rather than simple observation." Assuming that Dr. Nelson means *scientific* observation by his term "technical methods," and not just instrumental recordings, I can make the case that **degrees of articular mobility can logically and reliably be inferred from scientific observation of changes in bony landmark position from symmetry to asymmetry,**

→

or from asymmetry to symmetry. A scientific observation is one for which there is a defined and reproducible protocol. The method my father and I used combined palpation (for locating the landmark) with trained visual observation (for comparing landmark position).

I believe the reason Dr. Nelson finds the terms ilio-sacral and sacroiliac (terms used in, but not originating with, the Mitchell Model) confusing is that he tries to use them in the Chicago Model without understanding what they mean in the Mitchell Model (“primary versus secondary dysfunction”?). Adaptations are not secondary dysfunctions. If an adaptation, over time, becomes a compensation, it can be called a secondary dysfunction. “Lesions” which self-correct after resolution of the primary dysfunction are not secondary dysfunctions or any other kind of lesion; they are adaptations. Dr. Nelson’s quotation of Fryette addresses this issue: “There is probably no single factor which attracts the attention of osteopathic physicians so quickly as asymmetry. However, asymmetry is not always indicative of pathology.” Dr. Nelson seems to assume that asymmetry is *never* indicative of pathology, or at least not reliably.

The terms iliosacral and sacroiliac have nothing to do with “primary or secondary dysfunction.” They refer to different physiologic articular mobility functions—those produced by lower extremity movement (**iliosacral**) and those produced by spinal movement (**sacroiliac**). The loss of one of these specific physiologic movements can be characterized as dysfunction of one or the other. Dr. Nelson makes the same distinction: “. . . dysfunction between the sacrum and ilium should be named for the sacrum relative to the ilium. Iliac dysfunction patterns are best defined in terms of one ilium relative to the other and, typically, have dysfunctional involvement of the symphysis pubis.” (*italics mine*)

Obviously, I have no argument with the above quoted statement up to, but

not including, the italicized part. In the Mitchell Model, measurable positional asymmetry of the pubic crests indicates pubic **subluxation** (ICD Code 839.69), not **dysfunction**—“restriction of normal articular motion” (Nelson). Iliolial asymmetries, dysfunctional or adaptational, should not be labeled pubic dysfunctions even though there is a slight elastic deformation of the interpubic joint, typically not enough to measure clinically.

Applying Fryette’s Type I and Type II paradigm to sacroiliac dysfunctions by assuming that they are actually lumbosacral dysfunctions is definitely a mistake. I hope no one takes this notion seriously. Non-neutral dysfunction of the lumbosacral joint may cause adaptive shifting of sacral position, but should not be blamed for maintaining sacroiliac dysfunction. Trying to create a “unified~ theory by mixing Fryette’s spinal theories with Mitchell’s pelvis model is too much like counting apples for oranges.

Failure to discover any sacroiliac or iliosacral axes in cadavers in no way invalidates the Mitchell model of physiologic pelvic joint motion. (“...although axes of sacral motion are conceptually useful, the body of available data does not support their existence.”) However, for the record, anatomists *have* described and named a ligament — the *short axial* ligament (identified in Dr. Nelson’s Figure 2 as the *short posterior ligament*)—which is part of the posterior sacroiliac ligaments, that seems to correspond precisely to the superior transverse axis—a postulated axis for some of the nutation movements of the sacrum between the ilia.

Nelson says, “Research into sacral motion has clearly demonstrated that sacral motion upon fixed axes of rotation does not occur.” A sacral nutation axis for breathing motion was demonstrated by Mitchell (Jr.) and Pruzzo in 1971 using roentgenographic techniques similar to Kottke’s. Contrary to popular opinion, it is located anteriorly on the auricular surface at S₂ where the surface bevel changes angle. The larger

sacroiliac nutation ranges measured roentgenographically by Kottke were appropriately not analyzed for rotation axes, since it could not be established that the instantaneous rotation axis stayed in the same place throughout the full range of trunk flexion to extension. Anatomists have proposed that, at least for part of the nutation range, the short axial sacroiliac ligament—the physical analog of the superior transverse axis in the Mitchell Model—establishes the transverse axis for sacral nutation. Clearly translatory movements of the sacrum relative to the ilia do occur in the pelvis.

A particularly troublesome issue is whether there is physical evidence of the existence of oblique sacroiliac axes. Here Fred Mitchell, Sr., has confused a generation of serious osteopathic students, including Dr. Nelson, by postulating that, in the walking cycle, *lumbar sidebending* engages the oblique axis. My revision of the original Mitchell Model takes exception to this concept and postulates a stance phase continuous contraction of a *piriformis* muscle, a known anatomic structure whose action is in line with the oblique axis named for the opposite side of the body. Assuming the *piriformis* selects the operant oblique axis, lumbar sidebending may determine the direction of sacral rotation, but not the side of the oblique axis.

There is much in Dr. Nelson’s article with which I agree. For example, (Nelson): “The term forward torsion ... by itself does not indicate specific articular dysfunction.” It also describes the normal physiologic adaptive movements of the sacrum which are part of the walking cycle. It is specific **sacroiliac dysfunction** (ICD code 739.4, not 739.5) only *when that physiologic walking cycle movement is restricted*.

However, because of the key points discussed above, I find that I cannot agree with any of his conclusions.

Collegially,
Fred L. Mitchell, Jr., DO, FAAO, FCA
Professor Emeritus of Biomechanics
Michigan State University□

“A Functional Orientation for Technique”

May 15-17, 1998

William L. Johnston, DO, FAO and Harry Friedman, DO

Program

Friday, May 15, 1998

- 8:00 am Introduction: Problem-solving somatic dysfunction (SD) starts with a screening exam
- 8:30 am A selection of regional tests: demo, discussion and practice
- 9:45 am Break
- 10:00 am Standardizing a record of SD
- 10:30 am A second practice and record: sample the reliability of positive signs of SD
- 12:00 nn Lunch
- 1:00 pm Introduction: segmental motion dysfunction
- 1:30 pm Percussion scan: spinal regions
- 2:15 pm Segmental motion testing, cervical supine: practice
- 3:00 pm Break
- 3:15 pm Respiratory motion testing: demo and practice
- 4:15 pm Functional manipulation, cervical supine: practice
- 5:00pm Adjourn

Saturday, May 16, 1998

- 8:00 am Concept: afferent reduction
- 8:30 am Functional manipulation, thoracic: demo and practice
- 9:15 am Concept: segmental feed back control and the muscle spindle
- 10:00 am Break
- 10:15 am Position and motion: demo and practice, thoraco-lumbar
- 11:15 am Functional approach to the appendages: demo
- 12:00 nn Lunch
- 1:00 pm Functional approach to the sacro-pelvic region
- 1:30 pm Tissue and motion scans in diagnosis: demo and practice
- 2:45 pm Break
- 3:00 pm Manipulative technique, sacro-pelvic: indirect and direct applications, demo and practice
- 4:30 pm Functional manipulation, appendicular: practice
- 5:00pm Adjourn

Sunday, May 17, 1998

- 8:00 am Functional approach to the thoracic cage
- 8:30 am Tissue and motion scans in diagnosis; demo and practice
- 9:15 am Rib dysfunction resisting exhalation; tx. demo and practice
- 10:00 am Break
- 10:15 am Rib dysfunction resisting inhalation; tx. demo and practice
- 11:15 am Differentiating somatic and visceral inputs in segmental dysfunctions
- 11:30 am Discussion/Summary
- 12:00 nn Adjourn

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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.

Osteopathic Considerations in Systemic Dysfunction: Timely Treatment for Common Problems

June 12-14, 1998

Philadelphia College of Osteopathic Medicine; Philadelphia PA

Osteopathy shines in the hands of the primary care practitioner who utilizes it for non-musculoskeletal conditions, as well as musculoskeletal. The concept of using the musculoskeletal system as a "handle" to effect visceral functioning is a legacy Dr. Still has left to me world through the osteopathic profession. The sicker the patient, the more they need osteopathic manipulative care and the more important is the treatment dosage.

This course synthesizes the thought process of the osteopathic legacy and applies it to distinct clinical conditions. The registrant should expect to leave knowing not only a protocol for treating these specific clinical entities, but a protocol that he or she can then apply to their osteopathic care of any patient..

Karen M. Steele, DO, FAAO

► 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 & 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.

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June 12-14, 1998

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Twenty-Second Thomas L. Northup Lecture

Recollections

by Edna M. Lay, DO, FAAO

Editor's Note: Edna Lay earned her Doctor of Osteopathy degree from the Kirksville College of Osteopathic Medicine in 1946. She completed an internship at Doctors Hospital in Columbus, Ohio.

Dr. Lay joined the faculty of KCOM in 1973 and remained there until her retirement in 1985. During her career as an osteopathic physician, she has held the position of president of Osteopathic Physicians and Surgeons of California and served on its Board of Directors as well as various committees. Dr. Lay has served the American Academy of Osteopathy as a member of its Board of Governors, Board of Trustees, and as an examiner of the AAO Board on Fellowship. She has served as president of The Cranial Academy, a trustee of the Sutherland Cranial Teaching Foundation, a consultant of the National Board of Osteopathic Examiners and a president of the National Osteopathic Women Physicians Association.

Dr. Lay has written articles and has had them published in the *JAOA* and *Osteopathic Annals*. Most recently, she has authored Chapter 64 in the textbook *Foundations for Osteopathic Medicine*.¹ Dr. Lay has been the recipient of several awards throughout her career, including the highest award given by the American Academy of Osteopathy, the A. T. Still Medallion of Honor in 1994.

In all of her work as a physician and teacher, she has remained true to the osteopathic concept upon which

the profession and the Academy were founded. In recognition of her loyalty and of her many contributions to the osteopathic profession and the American Academy of Osteopathy, the Academy seems it an honor to present the twenty-second Thomas L. Northup Lecturer Award to Edna M. Lay, DO, FAAO. Her lecture follows.

It is indeed an honor to be invited to present the Thomas L. Northup Memorial Lecture for 1997. After reading Dr. Stiles scholarly lecture for 1996, I thought "What can I possibly say that would be of interest to this group?"

I decided to address the younger members of the Academy and share some of my recollections of events that were important to the Academy and to the profession. All of you have heard about the merger that occurred in California in 1962. Young physicians asked me to tell them what occurred and how it came about. It is a long, complicated story and difficult to relate. Nonetheless, I will begin with a brief history of osteopathy in California.

The first DO in the state opened his office in San Francisco in 1895. Licensing of osteopaths began in 1901 under state statute, and in 1907 the legislature passed California's first Medical Practice Act which established a Board of Medical Examiners composed of nominees of the various allopathic, eclectic, homeo-

pathic and osteopathic schools of medicine. That Board was empowered to license the practice of medicine and surgery, osteopathy, and "any other system or mode of treating the sick."

In 1913, the original Medical Practice Act was repealed. The 1913 Medical Practice Act came into existence and is the source of much of the current code. It created a new Board to be appointed from among persons who "hold licenses under any of the Medical Practice Acts of this state" — that is, osteopaths could, but were not required to be members of that Board. Beginning in 1913 the Medical Board granted at least 288 physician and surgeon licenses to osteopaths.

However, the osteopathic profession began to be harassed by the Medical Board. Finally in 1919, that Board arbitrarily refused to examine any more osteopaths and withdrew its approval of the College of Osteopathic Physicians and Surgeons (COPS) in Los Angeles, California. COPS went to court in 1921 (COPS vs. the Board of Medical Examiners.) After an exhaustive investigation and trial, the court held that COPS was entitled to the approval of the Board, and its graduates to examination and admission to the practice of medicine and surgery. The Court ordered the Medical Board to continue the examination and licensure of osteopathic graduates.

Nevertheless, in spite of the court action, the tensions between the osteopaths and the allopaths continued.

After continued and diligent efforts the osteopathic physicians and surgeons managed to place on the ballot an initiative act which was approved by a vote of the people in 1922, which established a Board of Osteopathic Examiners with the power to grant physician and surgeon certificates to DOs, and enabling the osteopathic profession to become a separate, independent, self-controlling, self-disciplining profession. (Keep in mind, an act voted on by the people cannot be amended by the legislature—only by a vote of the people.)

From 1922 to November 1962, the osteopathic profession grew steadily in number to more than 2,600 practicing physicians. They built 65 hospitals in the state, largely from their own funds; staffed Unit II of the Los Angeles County Hospital, one of the largest tax-supported hospitals in the country; and provided skills and financial support to their non-profit, independent college, COPS.

The California Medical Association (CMA) was not pleased with the growth and success of the California Osteopathic Association (COA.) A planned conspiracy was brewing secretly between a small number of MDs and a small number of DOs. This conspiracy was active for 15 or more years prior to its culmination in 1962 in the form of a merger between the two associations. This conspiracy came to light in 1959 at the meeting of the American Osteopathic Association's (AOA) House of Delegates. At that meeting, the California delegates were asked if the COA was planning a merger with the CMA. Their answer was "yes." Previously they had denied that a merger was being planned. Following that very disruptive meeting, the COA lost its charter with the AOA.

I was not aware of any of these political maneuvers until later. I attended my first cranial course in 1949 and attended the second one in Oakland, CA in 1958. I met some of the

DOs in California by attending Study Group meetings and local Academy meetings in Los Angeles. At these meetings I met Drs. Isabell Biddle, T.J. Ruddy, Viola Frymann, Olive Stretch, Ethan Allen, Arthur Moore and others. I recall an Academy meeting for which Drs. Fred Mitchell, Sr., Paul Kimberly, and Irvin Korr, PhD were scheduled as a teaching team. I was very much impressed by that weekend program. Dr. Kimberly taught detailed applied anatomy; Dr. Mitchell demonstrated how he diagnosed and treated the pelvis; and Dr. Korr lectured on the neurophysiologi-

My first clue that something was amiss, was receiving in the mail an envelope containing papers offering an MD degree, with a paper to sign and return along with a check for \$65.

cal ramifications of dysfunction of the lumbar spine and pelvis. I believe that was one of the first programs of an Academy-sponsored teaching team.

I received my California license from the Board of Osteopathic Examiners in 1960 and started practice in Ojai. I was never a member of the COA. My first clue that something was amiss, was receiving in the mail an envelope containing papers offering an MD degree, with a paper to sign and return along with a check for \$65. My reaction was, "What the hell is this?"

I shall return to the history of the California merger. The agreement between the COA and the CMA called for the following:

1. Both organizations were to use their best effort to *get the legislature to provide that under certain circum-*

stances the licensed osteopath, if he so desired, could be authorized to use the designation MD.

2. The Osteopathic Board was to retain jurisdiction over licensed osteopaths, but if a DO became an MD the jurisdiction over him would be transferred to the Medical Board.

3. When the number of DOs reached 40 or less, the legislature might repeal the Osteopathic Act of 1922 and transfer all the functions of the Osteopathic Board to the Medical Board.

4. No new or additional physician and surgeon licenses were to be issued by the Osteopathic Board. The Board retained its regulatory duties.

5. COPS was to be converted to an allopathic school issuing MD degrees.

6. The parties to the agreement were to mutually support what became the Initiative Ballot Measure of 1962 known as Proposition 22.

COPS was transferred to the CMA and the CMA, in turn, transferred it to the University of California. It is now U.C. Irvine. This college would issue MD degrees for the sum of \$65 to those osteopaths who held an osteopathic physician and surgeon's license in California and who elected to take the MD degree. After obtaining the MD degree the former DOs would be required to transfer their license to the Board of Medical Examiners under the authority of a special statute to be passed in 1961—before the 1962 election. And legislation would be enacted through the mutual efforts of the two associations to prevent the further licensing of osteopathic physicians in the state of California.

Note that certain legislation had to be passed to finalize certain parts of this merger agreement. The persons who planned this conspiracy had planned for that contingency also. There was a member of the California legislature, a DO named Stephen P. Teale. He and his wife were DOs

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practicing in the small community of West Point in the Sierra Nevada mountains. He was the senator who authored and used his influence to pass the enabling legislation. He was the only physician in the legislature, and he was Chairman of the powerful Senate Finance Committee.

After the COA lost its charter with the AOA, some of the DOs who were strongly opposed to the merger organized into a new osteopathic professional association, Osteopathic Physicians and Surgeons of California (OPSC) and received a charter from the AOA. They formed a Board of Directors, elected officers, and began to function in opposition to the proponents of the merger. The enabling legislation had been passed and it appeared on the November ballot in 1962 as Proposition 22. The legislation made changes in the Osteopathic Act of 1922 and required a vote of the people for approval. In two weeks it will be the thirty-fifth anniversary of that fateful election. The CMA spent more than a million dollars on that campaign for "Yes vote on 22." On television, their message was, "for better health care, vote yes on 22." There was no mention of the merger or osteopaths or any other aspect of the real issues. Of course, the public wanted better health care. Most people did not read the fine print and if they did read it, they did not understand it. Proposition 22 passed!

We lost COPS and only five osteopathic colleges remained in the United States. We lost 65 osteopathic hospitals. About 2,100 DOs bought the MD degree. They assumed they would be invited to join one of the various county medical societies. They were not. There were 40 county societies. The CMA created the 41st medical society for the osteopaths turned "MDs." So they were still ostracized from the general medical community.

But the most important loss to us was that the Board of Osteopathic

Examiners lost its power to examine and license DOs. This sounded the eventual death knell for Osteopathy in California.

The officers and directors of OPSC started a twelve year battle with the CMA in the legislature and with the Attorney General in the courts to regain the right of DOs to be licensed.

I was appointed Chairman of the Legal and Legislative Committee of OPSC. After numerous legislative attempts to change the 1962 law pertaining to the Osteopathic Board's power to examine and license—all

But, the most important loss to us was that the Board of Osteopathic Examiners lost its power to examine and license DOs. This sounded the eventual death knell for Osteopathy in California.

of which failed, we made contact with a lawyer, Alexander R. Tobin. This was a chance meeting; perhaps an act of providence. There had already been two or three cases in the courts which had not been successful for various reasons. One declared that the merger was in violation of the Sherman Antitrust Act. One contended that funds given to COPS which were earmarked for "osteopathic education" were being misused.

After study and investigation into this complicated situation, we hired Mr. Tobin to start a legal case in our behalf. It was based on violation of civil rights, the right of a citizen to make a living, the right of a DO to practice in California. He wanted as plaintiffs a group of DOs who collectively represented graduates of

each of the six osteopathic colleges who were licensed to practice in other states and who were or had been members of each of the branches of the U.S. Armed Forces. I helped him locate these individuals to get their permission to use their names and credentials. He asked each of them to make application to the Board of Osteopathic Examiners and the Board of Medical Examiners requesting permission to be examined for licensure. Of course each of them received replies denying their request.

The Petition contained many other exhibits—the total effect of which demonstrated the paralleling, equivalence, and quality of education, training, and competence of the DO and the MD. The defendants in the case were the Board of Osteopathic Examiners and the Board of Medical Examiners which were both represented by the Attorney General of California. The first hearing was before the Superior Court in 1968.

I cannot recall all of the appeals, stalling tactics, legal machinations and delays that followed during the next six years. In 1971, we got a favorable ruling from the Superior Court. The Board of Medical Examiners appealed again and employed all of the stalling tactics known to the Attorney General. We anticipated that the case would be finalized in 1972 but it was not. In 1973, I passed the responsibility as Chairman of the Legal and Legislative Committee of OPSC to Dr. Ethan Allen. I moved from Ojai, California to Kirksville to join the faculty in the OMM Department of the College.

The case was appealed to the Supreme Court of California which rendered its decision March 19, 1974 in our favor. The power to examine and license DOs as physicians and surgeons was restored to the Board of Osteopathic Examiners!

As you may surmise, the legal fees for this case which continued for six years were a large amount.

OPSC started the legal action and was responsible for paying the bills. We asked for help from the AOA repeatedly. At first we got no help, the trustees viewed our situation as "sending good money after bad." The previous cases in court had not succeeded. But as our case progressed and they began to understand it, they did help us.

I traveled to Chicago and other cities numerous times to appear before the AOA Board of Trustees to report on "the California situation." My responsibility as OPSC's Chairman of the Legal and Legislative Committee was to function in the legislature as a lobbyist representing the osteopathic profession in California. I knew nothing about working as a lobbyist. I remembered from my eighth grade civics class that the legislature made laws. About politics, I was totally naive. I was also very, very angry at those who planned and carried out the conspiracy including the DOs who bought the "MD" degree. Anger is not a healthful emotion but it certainly stimulates one into action. I made innumerable trips to Sacramento for nine years acting as legislative advocate for OPSC. At first we tried to get a bill through the legislature to restore to the Osteopathic Board the power to examine and license DOs. Senator Teale's opposition was too strong. After we filed the case in court, I had to watch the bills moving through the legislature to be sure that no bill passed that could nullify our court case. I also watched bills that made changes in the Medical Practice Act to be sure DOs were included in the wording of the bill if it pertained to practice rights. This required being at Committee hearings of bills and speaking on behalf of the osteopathic profession, which was always in opposition to the advocates who spoke for the CMA.

Mr. Tobin helped me learn the basics; how to find my way around the Capitol Building, where to get copies of new bills, where Committee Hearing rooms are located and which bills will be heard and when. I helped

him learn about osteopathy and the osteopathic profession. As the case progressed in court, he was challenging the Attorney General and his large staff of lawyers including advice from the CMA and the American Medical Association (AMA.) There are very few lawyers who are willing to go up against that kind of opposition. He was threatened with economic sanctions and was warned that "various troubles and all kinds of dark things would come his way if he did not terminate his crusade for the osteopathic profession. . ."¹ He was steadfast in his pursuit of justice for the DOs and in halting the "death knell" of osteopathy. He was a man of integrity.

About the time of the merger in California, there was a plan in Pennsylvania to eliminate osteopathy by getting control of the Philadelphia College of Osteopathy, but it did not succeed. Later, there have been attempts in Missouri, Texas, and other states to eliminate osteopathy by one means or another. That reminds me of a statement made by Dr. Wallace Pearson on this subject. "Be careful, do not let them kiss you to death."

The victory in California could not have been accomplished without the help of many people. The OPSC Board was supported by the membership in the state as well as associate out-of-state members. Our patients also gave support. One of Dr. Frymann's patients helped start an organization of lay persons, Californians in Support of Osteopathy. They helped educate the public concerning the inequity of the law created by the merger, and they contributed funds to our cause.

This fiasco which occurred in 1962 was a shock to the whole profession. We had five remaining colleges and a large number of osteopathic hospitals. During the past thirty-five years there have been drastic changes in our professional affairs. We now have nineteen colleges but most of our hospitals have been sold to hospital management corporations. Medical care decisions have

gradually moved from doctors' offices to insurance companies and medical management corporations. In order to be paid for their services, doctors are required to "fit into" the corporations' list of benefits and services.

Who are the persons who sit on the Boards of Directors of these corporations? They are experts in finance to be certain that the insurance companies and medical management corporations make a profit. And they are *allopathic physicians* who make decisions concerning which medical procedures will be compensated and which will not, and how much the compensation will be. For a number of years this "squeeze" has been put on osteopathic physicians whose services include osteopathic manipulative treatment. The Academy members have been struggling against this discriminatory action for some time.

Is this action part of a plan to squeeze out those osteopathic physicians who depend on payment for their osteopathic manipulative services by starving them out? If young physicians cannot make a living using OMT, their practices will gradually shift from osteopathic family practice to allopathic family practice, not by name but by mode of practice. When fewer and fewer osteopathic physicians give osteopathic manipulative treatments, there will be no distinguishing therapeutic factor in the delivery of health care. And, osteopathy will have been eliminated.

I do not want to see this happen, and you do not want to have it happen. But, it could happen if we are not vigilant. Having struggled through the events in California in the 1960s, I am very much aware of the opponents desire to eliminate the osteopathic profession. I believe their desire is the same; only the tactics are different.

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Psychosynergisis[®], a synthesis of cranial osteopathy, acupuncture, and homeopathic medicine in psychiatry[©]1995

by Krishnahari S. Pribadi, MD

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Abstract

Psychiatric disorders are associated with abnormal bioenergetic patterns. Psychiatric symptoms represent the manifestation of constellation of dysfunctional internal organs, abnormal craniosacral mechanism and disharmony of the human bioenergetic system. The author describes his Therapeutic system (Psychosynergisis) based on the synthesis of cranial osteopathy, acupuncture and homeopathic medicine. It is his contention that the craniosacral system (a physiological system discovered by William G. Sutherland, DO, the founder of cranial osteopathy, comprising of the inherent mobility of the brain and spinal cord, the fluctuation of the cerebrospinal fluid, the mobility of the intracranial and intraspinal membranes, the articular mobility of the

cranial bones and the involuntary mobility of the sacrum between the ilia) is the fluid wave regulatory system in the body that connects the central nervous system with the acupuncture meridian system. Cranial osteopathic manipulation can be used to correct the abnormal craniosacral mechanism commonly found in psychiatric patients. The bioenergetic manipulation of the acupuncture meridian points in conjunction with cranial osteopathy and the synergistic use of homeopathic remedies or microdosed herbal formulas may result in the correction of the abnormal bioenergetic patterns and thus aiding in the healing process of patients with psychiatric disorders.

Introduction

The term Psychosynergisis[®] was coined by the author in 1991 when he encountered that psychiatric symptoms could be modified by bioenergetic manipulation of the energy-sensitive points on the skin surface during body-mind therapy sessions.¹ Having conducted a few thousand hours of bioenergetic sessions with psychiatrically-disordered patients, he concluded that most psychiatric symptoms are caused by the dysynergistic state of the human body. This state is usually created by physical and/or emotional traumatic events or injuries in the past which cause the disarray and chaotic patterns of the human bioenergetic system. It

is his contention that the bioenergetic system is centrally associated with the regulatory and cybernetic physiological mechanism registered at the holographic memory fields within the craniosacral system which stores the memories of the original trauma. These unresolved memories eventually result in the disruption of the regulatory psychophysiological mechanism.³ In this paper, the author presents his therapeutic system to treat various psychiatric disorders which he has developed on the basis that corrections of the abnormal bioenergetic patterns in psychiatric patients can lead to recovery from mental illnesses and symptoms.

Acupuncture medicine

Access to the bioenergetic system can be achieved by direct interaction with the fields through access points in the body as represented by the acupuncture meridian points. There are at least 12 recognized major meridian lines in the body which are essentially bioenergetic lines that connect internal organs with the external world as well as the central nervous system. The nature of this bioenergy is currently still unknown. However, it has been demonstrated that wave pulses or electric/magnetic/laser pulses have significant impacts upon the acupuncture points. It is speculated that each acupuncture point has its own frequency resonance to

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which it responds accordingly either by passing, blocking, or modifying information through the meridian line in which the point is located. Capel has shown that low frequencies delivered at the auricular points produce different biochemical effects in terms of the types of endorphin fragments generated as compared to those caused by higher frequencies. The peak waves appear to be more effective in releasing endorphin fragments as compared to square waves.³ Furthermore, it was discovered that the frequency of the applied electrical stimulation to the auricular acupuncture points determined the efficacy of neuro-electric therapy in various addiction states. Hard addiction appears to respond better to high frequency (above 100 cycles per second). Addiction to nicotine responds well to a frequency of 10 cycles per second. Alcohol addiction appears to respond better to a frequency of 100 cycles per second.⁴

In summary, acupuncture points are gates as well as windows within the acupuncture meridian system. Each point has its own threshold and specific frequency sensitivity. Voll, using electric acupuncture method in thousands of patients, has demonstrated that specific points upon the specific meridian represent the functions of certain parts, organ or processes in the organ that are traversed by the specific meridian bearing the name of the organ. Thus, it can be stated that acupuncture points have specificity in terms of their sensitivity to specific frequency ranges, specific energy forms and specific physiological responses. By needling specific acupuncture points, the physician can manipulate the disease process that occurs at the specific parts or can correct specific abnormal physiological responses. Furthermore, the acupuncture points usually have high skin conductivity which can be measured electrically, thus aiding in the detec-

tion of the points.¹⁴ It is estimated that there are thousands of those acupuncture points on the body surface that are sensitive to external as well as internal manipulation/stimulation. In a way, these points can be considered to be part of the bioenergetic regulatory system of the human body. The meridian lines serve as the channels that convey information and bioenergy back and forth between the internal organs. It is speculated that these lines contain specific fluid that respond to fluid waves generated at the acupuncture points, organs, fluid compartments, or any source of fluid wave impulses within the human body. All fluids within the body intercommunicate through the links served by these meridian lines. The meridian system is considered to be the fastest system within the body that conveys information and delivers bioenergy from one site to another site capable of crossing the boundaries between parts in the human physiological system. They connect distant parts as well as parts that are within a physiological unit. Thus, the central nervous system can communicate with the immune cells by simply delivering the information through the specific meridian lines that are connected to the brain in addition to using endogenous neuropeptides released into the body fluids. These wave pulses are communicated through the lines to be picked up by specific immune cells located in any part of the body. Although structurally the meridian lines have not been proven to exist in the body, they appear to be closely associated with lymphatic channels that are abundant in the body. Direct links between the lymphatic system, meridian system, and the central nervous system appear to be responsible for the widespread yet specific impacts of the central nervous system upon the body and vice versa.

Craniosacral system

It is the author's opinion that the craniosacral system is the fluid-wave regulatory system that connects the central nervous system with the meridian and lymphatic system in the body. The craniosacral system was discovered by William G. Sutherland, the founder of cranial osteopathy, who developed the system of therapy based upon the manipulation of the cranial bones to create systemic as well as specific changes within the body.⁵ This system is considered to be a semi-open hydraulic unit bounded by the intracranial as well as well intraspinal dural membranes. The system contains the cerebrospinal fluid generated by the choroid plexus within the brain ventricles which produce active ingredients that have physiological effects. The choroid plexus are supplied by the brain capillary system and appear to receive multiple feedbacks from the body including the stress receptors located in the cranial sutures which regulate the production of the cerebrospinal fluid.⁶ The fluid continuity is as follows: lateral ventricles, foramina of Monro, third ventricle, cerebral aqueduct, fourth ventricle, foramen of Magendie, and foramina of Luschka, and the subarachnoid space of the cord. The cerebrospinal fluid is reabsorbed by the circulatory system via the Pacchionian bodies into the venous sinuses which are directly connected to the internal jugular veins. Some escapes by way of the perivascular spaces and the hollow collagen fibers of the fascia into the lymphatic system. The existence of the craniosacral system owes to the presence of the five components known as the cranial concept/mechanism:

1. The inherent motility of the brain and spinal cord.
2. The fluctuation of the cerebrospinal fluid.
3. The mobility of the intracranial and intraspinal membranes.
4. The articular mobility of the cranial bones.

5. The involuntary mobility of the sacrum between the ilia.

All five components interact dynamically with each other to produce what is called the cranial rhythmic impulse (CRI) at the frequency of between 10 to 14 cycles per minute in normal individuals. This impulse can be palpated by a trained physician in any part of the body, but particularly the skull and the sacrum.

Sutherland considered that the cerebrospinal fluid not only has a definite fluctuation but also has an inherent physical potency/energy which acts upon the body as a hydrodynamic force and an inherent electrical potential that has both positive and negative phases. He called the system as the *primary respiratory mechanism* as opposed to the *secondary respiratory mechanism* responsible for the pulmonary respiration. CRI has two definite cycles called the inhalation (flexion) and exhalation (extension) phases and represents a dynamic metabolic interchange in every cell. It is therefore seen as a regulatory complex that transcends any agencies within the body.⁷

Patterns of diseases are produced by the disturbances of the somatic component of the craniosacral system, such as: the disturbances of the cranial mobility; connective tissue scars or injuries; compression of specific cranial bones causing interference with the dynamic flow of the cerebrospinal fluid; postural stress; facilitated segments created by irritation of the autonomic nervous system; obstruction and stasis of lymphatic flow; and entrapment neuropathy from the mechanical effect of the impinging adnexa. Treatment of the somatic component of the craniosacral system restores the primary respiratory mechanism which has wide ramifications upon the entire regulatory mechanism of the body including the structure as well as the chem-

istry of the whole organism. Although the primary therapeutic effect is delivered by the physician through physical manipulation of the somatic component of the craniosacral system, an open exchange of bioenergy occurs between the patient and the physician. This emphatic rapport has been recognized as an essential component in the bioenergetic regulatory treatment.^{2,13} The cranial rhythmic impulse becomes the significant detector by which the physician monitors the treatment process as the quality of CRI varies with the quality of energy exchange, tissue responses, vitality of the patient, disease processes, and treatment phases. CRI above 14 cycles per minute indicates mental stress, fatigue, overtaxing of the system, reduced vitality, and immunity. Depression, anxiety, and psychosis is frequently associated with CRI frequency above normal. Severe cranial compression, autism, severe depression, ADHD, brain damage, schizophrenia, regressed states, and severe pain are frequently associated with reduced CRI frequency and amplitude.⁸ The Psychosynergistic Diagnostic table (see table 1) developed by the author summarizes his findings regarding the nature of abnormal cranial mechanism and bioenergetic system in major psychiatric disorders.

The forces responsible for the healing process originate from these internal and dynamic forces rather than applied externally by the physician. The physician's role is primarily to direct these forces by removing resistance and obstacles that prevent the dynamic flow of energy within the body as represented by the quality and direction of CRI. The significant shift within the dynamic balance of the primary respiratory mechanism occurs during a phase within the cycle called the still-point. Exchange of energy among the fluid compartments inside the patient's body and between the patient and the physician occurs optimally during this *still-point*. It ap-

pears that the energy exchange that exists during this phase follows the open energy exchange principle as described by Prigogine.⁹ The synergistic state that occurs during this phase involving all meridian lines allows the system to decrease its entropy. The release of energy to the external system is accompanied by decrease of entropy and increased efficiency of the regulatory mechanism. In addition, frequently the release is accompanied by emotional releases and reliving of painful memory associated with the original traumatic states. Releases of foci of concentrated entropy in the body, associated with stressed organs, scar tissues, facilitated segments, and diseased processes are frequently facilitated during this *still-point*. The release of energy can be accompanied by the release of heat into the surrounding tissue and is usually heralded by the so called "therapeutic pulse". This pulse can be palpated by the physician at the local areas where the work is being done. The frequency is much higher than the frequency of CRI and often times comes in crescendo followed by decrescendo. It may also come in packets of impulses as if vibration is being sent by the tissue to the physician's hand. The reappearance of CRI and the disappearance of therapeutic pulse accompanied by the local release of heat and emotional releases indicate that therapeutic goals have been achieved optimally at the local level.

Still-point state can be achieved by many therapeutic techniques including compression of the fourth ventricle, mechanical energy delivered at the sacrum or both feet to induce a steady state, positioning of the limbs or body parts to mimic the original position of trauma, visualization and imagery, indirect technique to change cranial stress pattern, and exchange of energy with the physician who delivers this bioenergy at the vault in

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Disorders	CRI cpm	SCL mhos	Cranial Lesions	CRI to cold Challenge	SCR to cold Challenge	SCL Recovery	Affected Organ Fields/Meridians	Significant Acupuncture pts.
schizophrenia	LOW <4	LOW <9 slow	LOM/ROM Extension SBS comp	slightly elev. up to 30 cpm 4 x baseline	min. response + or - <1mhos	slow steady return	thyroid, hypothalamus, pineal, pituitary	GV22, ST10, MHN3 TB20, TB1
bipolar disorder	HI 12 to 120	HI 12 to >100	L. torsion Sidebend rotation Flexion	rapid response marked elev. 8 x baseline up to 160 cpm	steep resp. always + (up) up to 2-3 x baseline	labile + and -	heart gall bladder (+ in depression spleen, liver)	H9, GB 20 & Acpt. pts for Schizophrenia in psychosis & Acpt. pts in MDD in depression
major depression *associated with SBS comp. **Chronic fatigue Syndrome (CFS)	HI 12 to 80 *zero >80 in AIDS	HI 12 to 80	Torsion Sidebend rotation *SBS comp Flexion	mod. response up to 4 x baseline up to 100 cpm *no response in SBS comp.	mod. response always + (up) up to 2 x baseline	rapid return to baseline	spleen liver thymus gl. kidney (?) & hypothalamus, pancreas in CFS	SP1, SP6, SP15, SP6, KI (?), Li-1 Li-13, plus TB1, 20, Co, 13, 17, 24, MHN3 and L1, 2, 11 in CFS** (plus Co 8 in AIDS)
Anxiety Disorders eating disorder & obsessive comp. disorder	HI 12 to 80 zero	HI 20 to 100	torsion vertical strain SBS comp	mod response up to 2-3 x baseline (up to 100 cpm) no response	mod. response always neg. (down)	slow return to baseline	lung kidney (?)	L1, L2, L11
schizo- affective disorder	LO <4	HI 20 to 100	LOM/ROM extension or flexion	slight resp. up to 2 x baseline	flat resp. + or - < 1mhos or rapid resp.	slow return or labile	heart, pineal, hypothalamus, pineal, thyroid	H9, GV22, MHN3 ST10, TB20, TB1, GB20
attention deficit disorder (frequently associated with learning disability)	LO <6	HI 20 to 60	medial comp. & ext. rotation of L temp bone FP lesion sagital ridge, prominences	slight resp. up to 30	depends on comorbid psychiatric disorders	usually labile or depends on comorbid psychiatric disorders	inner ear/ mastoid, sympathetic syst. hypothalamus	TB1, TB20, GB20, Right NHN 54
substance abuse	←		DEPENDS ON	COMORBID DISORDERS			liver, brain	L1,L2,L11,Li1,13 →
seizure/brain damage alzheimer's	LO LO	LO? LO?	← DEPENDS ON COMORBID SBS/FPcomp	ON COMORBID DISORDERS			sympathetic system, brain	GB 19 (seizure) → MHN3

TABLE 1: This Psychosynergistic Diagnostic Table © (by K. Pribadi, MD, 1996) is developed by K. Pribadi, MD based upon a series of Cranial Osteopathic investigations of various psychiatric disorders from 1988-1996. The significant Organ Fields and Acupuncture points were determined by Pribadi-Upledger's sign (abrupt cessation of CRI when the significant organ fields/acupuncture points are palpated). SCL and SCR were measured using the Autogentm 3000, Feedback Dermograph manufactured by Autogenic Systems, Inc. SCL: basal skin conductance level. CRI: Cranial rhythmic impulse, SCR: Skin Conductance Response, LOM/ROM: Left/Right Occipito-mastoid lesions. SBS comp: sphenobasilar symphysis compression, FP: fronto-parietal. Acupuncture points used are according to the numbering system devised by the American Society of Chinese Medicine. This is not to replace the standard psychiatric interview but is intended to supplement the psychiatric diagnostic process. All rights reserved. This table may not be reproduced in whole or in part by any means without permission.

order to induce a steady state of exchange and somato-emotional release. The author has demonstrated that the skin conductance response is decreased considerably following the termination of this steady state, thus demonstrating that the autonomic nervous system is balanced and shifted towards the parasympathetic side.⁷ This indicates that upon the termination of the steady state (*still-point*) the bioenergetic pattern and the regulatory mechanism of the patient are improved and synergized. Frequently, there is a shift of the brain wave pattern from predominantly beta to alpha or even theta waves. The patient becomes extremely relaxed and often times has fallen asleep on the treatment table, feeling refreshed upon awakening.¹⁰

Auricular cardiac reflex, CRI, and homeopathic medicine

One interesting phenomenon that the author has consistently encountered is that the CRI can be used to detect pathological acupuncture points, areas of restriction, foci of entropy and old injury sites within the body as CRI will invariably stop as soon as these pathological points are palpated by the therapeutic hand or when the therapeutic hand is placed above the pathological areas. This phenomenon is difficult to explain. The only explanation that seems reasonable is that these pathological points become the windows through which energy exchange with the physician takes place. CRI will invariably return upon the removal of the physician's hand from the areas or when the therapeutic process is completed. This phenomenon is exploited by the author to induce a prolonged *still-point* by sequentially placing the therapeutic hand at those areas to suppress the return of CRI. The author took the liberty of naming this phenomenon (the abrupt cessation of cra-

nial rhythmic impulse upon the palpation of the significant acupuncture points and organ fields) as the Pribadi-Upledger's sign.

It is the opinion of the author that by inducing this prolonged *still-point* state, a synergistic state of the bioenergetic and regulatory mechanism is optimally achieved. Often times, this process is coupled by visualization to allow the patient to manipulate the pathological areas with his imagination which usually is accompanied by intense emotional releases, reliving of memory or a relaxation state. The phenomenon that the CRI can be used as a detector can be compared with the auricular cardiac reflex (ACR) discovered by Nogier who championed the Auricular Medicine.¹² As a matter of fact the author uses this phenomenon exclusively to detect pathological acupuncture points within the body and the auricles. It is more difficult to detect the auricular cardiac reflex than the CRI since ACR is very much affected by the cardiac and autonomic nervous responses. ACR is detected by placing the palpating thumb on the radial artery distal to the standing wave created by the interference pattern of the fluid waves traveling in the opposite directions. A positive ACR is felt when the examining thumb detects an increase of the amplitude of the radial pulse caused by the passing of the standing wave under the thumb. A positive ACR occurs when a palpator or a needle is placed on top of a pathological point on the auricle. Needling of the pathological point with either gold or silver needle will invariably revert the ACR back to negative. One can also place the seven-color filters upon the sympathetic skin (usually the forearm) while scanning the auricle area with the palpator or one pole of the positive/negative, gold/silver, black/white and north pole/south pole hammer designed to detect acupuncture points. These filters are regarded as tuning devices and serve to lower

the background noises so that only fewer and more specific pathological points are detected on the auricle. One can also use drug filters such as homeopathic remedies, nosodes, tissue complexes, morphine, noradrenaline, naloxone, allergens, etc. to detect specific points on the auricle requiring specific treatment. Of interest is the potential use of epiphysis (pineal gland) D4 as a filter to detect pathological points in psychiatric disorders. It is the author's opinion that CRI is a more sensitive and reliable indicator to detect the pathological points needing treatment as well as the amount of time needed for the treatment. CRI will cease to be detected as soon as treatment is applied to the specific point. When treatment is completed, CRI will invariably return and shows improved amplitude and more normal frequency. The author routinely monitors the CRI at the vault with one hand while the other hand (or an assistant or the patient's hand) is used to deliver bioenergetic force at the acupuncture points, "energy sensitive areas" during the treatment process.

Voll has shown that homeopathic remedies have specific effects upon the measurement when they are placed serially upon the circuit used to measure the electrical property of the acupuncture points.¹⁴ This technique is useful to determine the specific homeopathic remedies indicated for various disorders as well as psychiatric disorders. The author has developed and conducted studies on a few microdosed herbal preparations that specifically influence the frequency and quality of CRI. These preparations are virtually devoid of the molecules of the original chemical substances extracted from the herbs. This indicates that the craniosacral system is intimately connected with the bioenergetic system as represented by the acupuncture meridian system and

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that homeopathic remedies and microdosed-herbal preparations can affect the bioenergetic patterns of the body by working at the craniosacral system and the specific meridian lines at the bioenergetic level. Whitmont considers the characteristic emotional and mental traits of the patient to be the most practical guide in the selection of the effective homeopathic remedies. This empirical fact shows that psycho-emotional patterns are crucial in the development of specific disease patterns.²⁹

Conclusion

Psychosynergisis® can be defined as a bioenergetic regulatory treatment method that specifically facilitates the synergistic actions of the bioenergetic forces within the patient's body by removing obstacles, resistance and pathology that interfere with the dynamic balance of the bioenergetic system. It borrows the concepts from cranial osteopathy, acupuncture medicine and homeopathy, and it achieves its diagnostic and therapeutic results by the manipulation, correction, and regulation of the disordered bioenergetic patterns created by diseases. Psychiatric disorders including addictive disorders are frequently associated with the disruption of the bioenergetic dynamic balance. The symptoms represent the manifestation of the constellation of dysfunctional internal organs, abnormal craniosacral mechanism and disharmony with the environmental bioenergy patterns. Consequently, psychiatric disorders may not reveal structural, chemical, or gross pathological changes in the body but invariably are associated with abnormal bioenergetic patterns and craniosacral mechanism. One consistent and specific physical finding in psychiatric disorders is the presence of abnormal cranial rhythmic impulse.^{8,16} Theoretically, one can correct the disease patterns by improving the cranial

rhythmic impulse using specific techniques to influence the craniosacral system/bioenergetic system. Furthermore, one can delineate specific bioenergetic patterns for specific psychiatric disorders. The bioenergetic regulatory techniques such as EAV test, Mora therapy, Segmental Electrogram, Vega Test, Impulse Demography, Thermography, Theratest method and Ryodoraku (Japanese Acupuncture) can be useful in delineating the specific pathology as well as the specific treatment methodology for psychiatric disorders. Thus, Psychosynergisis® program can be summarized as follows:

1. Measure the meridian line system objectively using the Bioelectronic Regulatory Techniques such as the EAV Test or Vega Test to determine the patient's bioenergetic profile. The author uses the Autogen 3000 (Feedback Dermograph) to measure the skin conductance level of specific acupuncture points to develop the bioenergetic profiles of patients with psychiatric disorders. **Table 2** (next page) indicates some of the profiles in some of the patients who suffered from various psychiatric disorders.

2. Diagnose and treat the somatic component of the craniosacral system by specific cranial osteopathic manipulation technique.

3. Determine the pathological acupuncture points, foci of entropy, old injuries and scar tissue, facilitated segments, inflammation sites and active injuries by using CRI as the detector while the therapeutic hand is placed above the suspected significant areas on the body surface (acupuncture points, scar tissues, diseased organs, old injuries, etc.). If necessary, verify the findings with Dermatron or other bioelectronic devices to detect pathological acupuncture points.

4. Treat the pathological acupuncture points using the acupuncture medicine concept while monitoring the CRI at the vault. Depending on the specific findings, charging or discharging the points should be conducted accordingly. (The author uses his therapeutic hand or finger(s) instead of needles to discharge or charge the acupuncture points.)

5. Conduct psychotherapeutic dialogue including guided imagery and visualization techniques with the patient during the prolonged *still-point*. Facilitate emotional releases, resolution of conflicts and problem solving using psychotherapeutic, body-mind imagery, and behavioral techniques during *still-point*.

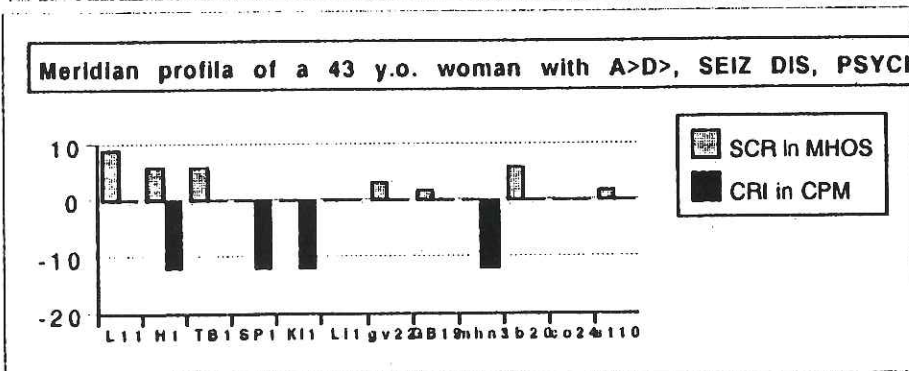
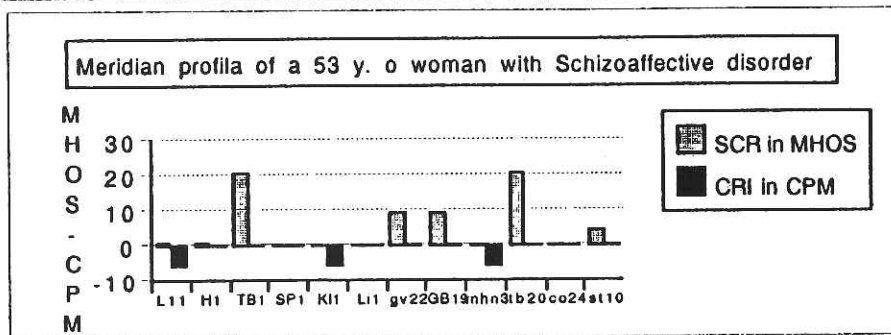
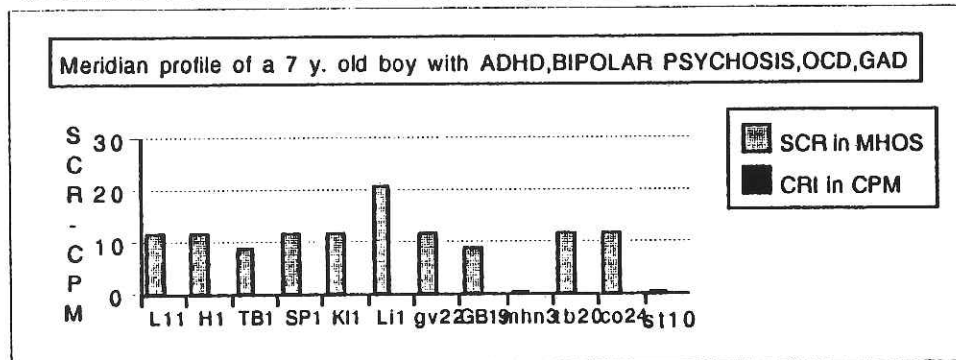
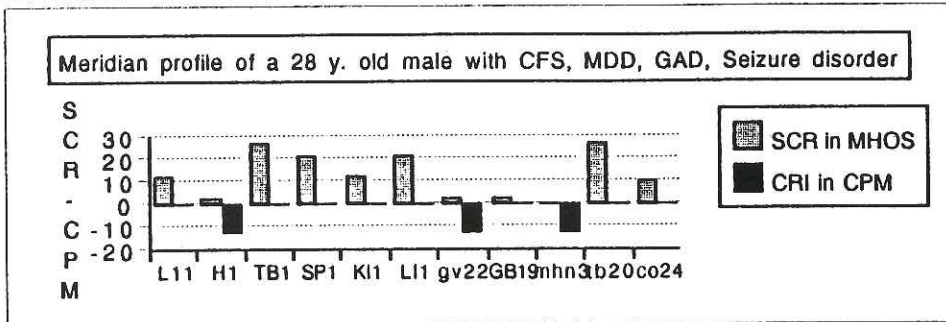
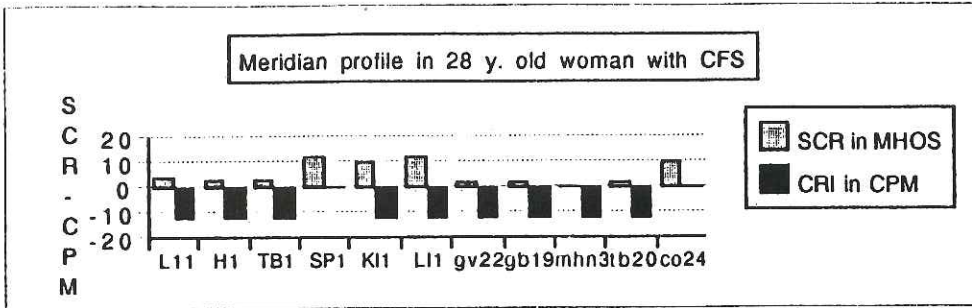
6. Re-measure the meridian line system using the same bioelectronic Regulatory Technique Test after interventions are delivered (if necessary).

7. If indicated prescribe homeopathic remedies according to the classical homeopathic principles aided by the bioelectronic regulatory testing or specific herbal remedies/formulas to support the affected bioenergetic system and specific organs.

8. Psychotropic medications can be prescribed judiciously as indicated by the severity, acuity or chronicity of the symptoms and psychiatric diagnoses provided that they do not interfere with the self-healing capacity of the patients caused by drug effects such as: drowsiness, cognitive impairment, emotional detachment, drug dependency, medical complications, etc. Psychosynthesis (and the cranial concept) has a place in psychiatry in that it can deliver more holistically oriented and refined diagnostic and treatment approaches and, indeed, is quite rewarding for the patient as well as the physician.

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Above X line are SCR; under are CRI of respective acupuncture points. Zero value of CRI indicates positive Pribadi-Upledger's sign. SCR: Skin conductance response. CRI: cranial rhythmic impulse. © by K. Pribadi, MD in 1996

Entering a Clinical Discipline

By William L. Johnston, DO, FAAO

Editor's Note: William L. Johnston, DO, FAAO, presented the Scott Memorial Lecture at the 1997 Kirksville College of Osteopathic Medicine Founders Day Program. Dr. Johnston is a 1943 graduate of the Chicago College of Osteopathic Medicine and is currently a Professor Emeritus at Michigan State University's College of Osteopathic Medicine. Dr. Johnston's résumé involves extensive curriculum development and osteopathic clinical research, which follows on 28 years of clinical practice in New Hampshire. His honors include Louisa Burns Memorial Address, the Gutensohn/Denslow Award, the A. T. Still Medallion of Honor, and the Volume 95 *JAOA* Northup Writing Award. His presentation follows:

Ladies and gentlemen, fellow students, all. It is a distinct honor to be your Scott Lecturer for 1997. My goal is to speak with you, each quite personally. How can I do that? What do we have in common? Together, we have at least one major thing in common, a personal interest in the **discipline** referred to as osteopathic medicine, a professional discipline, a clinical discipline. And, not surprisingly, that is not only what the Scott Lecturer is supposed to address, that is, also specifically, what I would like to explore with you.

I will be focusing, first of all, on Dr. Still, osteopathy was his discipline. I will have some remarks regarding **clinical discovery**, new **clinical knowl-**

edge, and you, each of you, as **scientists** in the clinical practice of osteopathic medicine. I will be dealing with each of these items, discovery, new knowledge, and clinical science, because they are descriptive of a **professional discipline**, a field for **clinical study**, and that is what you are entering.

Let me start with Dr. Still. Like many other clinical investigators, the patient was his field of study. He especially used palpation as a means to study the entire body, not only its structure and how it moved, but then, more broadly, the interactions of structure and the other systemic functions in their total clinical context. His clinical success affirmed his clinical skill. Our problem is to acquire / learn / and teach today, what has been, for the past 100 years, an area still difficult to communicate. I am referring to the physical exam, and palpable findings, especially when they are present on musculoskeletal (msk) examination.

For most osteopathic students, classes in physical examination begin the first week. In general, the history and physical exam engage all of our sensory skills in medical problem solving. They engage our visual skills, auditory, olfactory, sociologic, proprioceptive, but especially our palpatory skills. In addition to applying **sensory** perception, msk palpation demands also **motor** skills, administering procedures like motion testing, and then **psychomotor**, engaging the brain to interpret what we sense.

A. T. Still had all of these faculties

in abundance. His discovery process was through palpation. His new knowledge was relevant to a human structure that moves. He had no hesitation in recognizing movement as the primary body function that it is. But particularly, he was exploring movement function, and its interaction with the function of all other body systems, as a distinctive new emphasis in medicine. Much of medicine emphasizes **external** factors and the agents and end products in disease. In addition, Still was recognizing the remarkable **internal resources** of the body in health. When health was impaired, he looked for impediments to the body's internal delivery of those resources. His clinical insight was extremely innovative. He recognized and removed structural impediments, restored movement function, and observed the circulatory, respiratory and nervous functions returning to a healthy status. His new knowledge was about significant function in the body, positive signs of which he could palpate with his hands. Those positive signs were from bony and other soft tissues. They did not move as expected when he tested them for mobility. Again with his hands, he devised means to remove those functional impediments, allowing the body itself to return toward healthy function. The hands discover new knowledge, a discipline.

How did he communicate his new knowledge? Anatomy was immediately relevant to the body structures he was studying. The body was a ma-

chine and he applied mechanistic terminology and concepts, as well as anatomic references, to describe his work with it. He read the physiologic responses of the body, right at his fingertips, both in his examination and in his treatment procedures, but **anatomy** was his reliable knowledge base. His writings fully report his anatomic and **mechanical principles**.¹ They do not, however, include sufficient description of his palpatory procedures, that is, how he actually examined the body. Nor, did he detail his findings. Fortunately, he did freely demonstrate his techniques of manipulation, and he could demonstrate clinical results. Everyone, however encounters the same difficulty he encountered. How does one describe what one is palpating, and then using as a focus for manipulative treatment? All positive signs on physical examination bear the same burden. They are fundamental building blocks of medical decision-making, yet so difficult to verbalize, teach, and learn.

Now the issue of "being scientific" raises its ugly head. Physical signs are considered "subjective." You will hear this issue raised again and again. Better to rely on radiology, MRI, CAT SCAN, laboratory research, and all the other products of science that are more objective. They obviously have their place, but they often have the same problem. Someone reads and interprets the printout, quite subjectively. How is the level of agreement among readers? Science says not very good. I will come back to this issue.

What has happened in the intervening years, to help us better communicate today what Still struggled to report, at the turn of the last century? Obviously a lot has happened. The world of knowledge never stands still. I want to select only a few key items, ones I have found helpful in understanding some directions needed for the evolution of osteopathy as a clinical discipline. I prefer the term evolution, not revolution.

Sometime after Still's death in 1917, a number of renowned philosophers and scientists from other biomedical disciplines were coming together, joining their talents, to try to understand better the human condition.² They began to question the principle of **causation**. This straight-line cause-and-effect model had been so productive early on for programming specific research in the physical sciences. Was this model as appropriate for investigating **human** function? Scientists like sociologist Lawrence K. Frank were challenging their peers

. . . new studies are continuing to explore the neural basis for motor control in a movement system.⁸ To advance the clinical discipline of osteopathic medicine, what could be more important today than applying this new knowledge from the bioscientists, especially in physiology.

to recognize the importance of "the individual," where **heredity** and prior life-experience make each individual unique. (You notice I said prior **life-experience**, not **prior-life** experiences. Those may add a unique quality to Shirley McLaine, but they are not what I am referring to.) – a **unique heredity** and life experience –.

For example in illness, application of the principle of causation, appropriately, can draw major attention to a specific microbe. However Frank, like Still, was focusing attention on the totality of each individual, and the unique quality of a human being's response.³ There is seldom a given hu-

man response to any one isolated causal event. Rather, each response is tempered by the fact that, up to any given point, each individual has been actively changing within a unique sequence of life events developing an individual identity, and a very individual status of healthy function, and dysfunctions. Thus, in the study of human reactions, there is not necessarily a predictable effect from a given cause. The human response to a microbe can be adequate, or it can result in illness and disease. Our response to the tubercle bacillus is a good example of how both the adequacy and the disease can result. The human condition of illness is **multifactorial**. This beginning realization was spurring new advances in human science.

Frank visited here at Kirksville as a consultant briefly in the 1950s. By this time, the Harvard neuroscientist, K.S. Lashley was emphasizing the brain and spinal cord as "a system never quiescent."⁴ Rather, the system is "already actively excited and organized." Walter Cannon was contributing the principle of homeostasis, a principle for better understanding the organization of these active body functions. From each of these men, there was not only recognition of the discrete causal event. There was also an emerging priority for studying the human condition, both in the laboratory, and in the clinician's office.

Emerging from this same period was **system theory**,^{5,6} and Norbert Wiener's **cybernetics, the feedback of information for control of function**.⁷ Within that context, a new industry of computer technology emerged. You may be familiar with that. But for the human disciplines, (and if there is a computer listening, I am not implying you are not human) but especially for the human disciplines, this principle of feedback for control was revolutionary. From studies in neurophysiology came description of the muscle spindle, and feed

→

back for control of movement function. Increasingly, new studies are continuing to explore the **neural basis for motor control** in a movement system.⁸

To advance the clinical discipline of osteopathic medicine, what could be more important today than applying this new knowledge from the biologists, especially in physiology. A. T. Still did not have the advantage of this new knowledge. Yet, it is so intimately related to his clinical studies of the body's mobility, a mobile system, and how its interactions with other body systems influence health status. Today, we can consider not only bones and the anatomy of joints and mechanical principles, but also physiology and functional principles, and the *movement* of bones in a mobile system. There is growing opportunity to consider not only **structure**, and not just "a bone out of place," but also **structure/function**: bony and soft tissue structures and how they are organized, with feedback for control, to be in the right place at the right time, to move together as mobile units in a mobile system.⁹ Within this new field, some of our own research has led to documentation of a specific pattern of spinal dysfunction, **its persistence in time, and its association with persistence in elevation of blood pressure**, hypertension.^{10,11} Movement function and cardiovascular function systems interacting; how does their interaction break down? These are questions for basic science. However, it is often the clinician who can provide clinical clues to a direction the basic scientist will take.

You all know what science is, right? Before you make judgments about what is scientific, and what is not, let us look at **the process of scientific discovery**. What items are fundamental to any scientific protocol? You carefully state your question and describe your methods, you detail your procedures and establish criteria for findings, and then you can document response. Why,

these necessary steps? Obviously, so someone else can apply **your** procedures, with expectation that **your findings** will be reproducible/factual. Herein lies the scientific method. . .

Will science take place in your office, five, six, or seven years from now? In *Clinical Judgment*, Feinstein says, it will.¹² In fact, he says it quite clearly, and I quote: "During a single week of active practice, a busy clinician conducts more experiments than most of his laboratory colleagues do in a year." Will you be ready for that? Obviously, part of that scientific conduct is in the physician who applies

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the **knowledge base** of science. Part is in the application of **scientific instruments with standardized measures**. But that is not all. What about the **method** of science? John Dewey clarifies this other fundamental aspect of scientific conduct. It engages the clinician, in the office, with the patient. For me, it was a simple key, but it took a very complex book to express it. In Dewey and Bentley's book, *Knowing and the Known*, let me read you a brief **example** of what I call "complex": I quote: "In this transfer of matters at issue from their prior ontological setting into a context that is set **wholly and only** by conditions of the conduct of the inquiry, what had been taken to be *inherent ontological*

demands were seen to be but *arbitrary assumptions from their own standpoint*, but important distinctions of use and office in the progressive carrying on of inquiry."¹³ Now that is a sentence! (My editor might say it is almost as complex as what I try to write sometimes.) Dewey was discussing the conduct of inquiry . . . **acquiring knowledge**. The simplicity is that knowledge relies on the independent existence of a knower and of something to be known, example: the clinician and the patient. **Clinical observation becomes scientific, if**, you can report your findings in direct relation to the procedures used to elicit them. **Description of the procedure must provide the context of the knowing**, thereby establishing a proper relevance to the known, and creating a first-order fact during a clinical examination.

For myself in clinical practice, clinical research became a reachable goal. The physician's office can be a setting, appropriate to conduct inquiry for new medical knowledge. I did not need a half-million-dollar grant and a million-dollar lab to begin to observe with care, that primary machinery that allows us to be mobile to observe with my hands and record factually **what** was observed in the context of **how** it was observed.

When does this become blurred? The known becomes blurred when you report what you **think** you have found theories, rather than first-order facts. There is something very important about both the fact and the theory of a palpable finding. But everything can become blurred in our discipline if we seldom come to the point of distinguishing between them. This is crucial for communication. For one thing we can disagree freely in a discussion of theories and concepts; everyone can have a favorite theory, and contribute to the discussion. However, agreement should be possible when palpable facts are concerned. Clinical fact is our knowledge base

first, then you can theorize. Suddenly, Still's motion tests, and criteria, become key components for reporting the palpable findings that are not described! The full context of how he observed was missing from the important knowledge base he was trying to convey. Our own continuing struggle for terminology illustrates that the problem of distinguishing clearly between fact and theory was not his alone. I would like to give you a thousand examples, but that's part of your quiz, later. Do you easily distinguish fact and theory? Start thinking right now!

So – do you see yourself in clinical practice as a clinical scientist? Or simply, a practitioner of what is already known? I am issuing this challenge as one aspect of personal responsibility that students, and clinicians often do not assume. Instead, science becomes a tool out there somewhere else, to be applied, but not happening as an integral part of the way you think. Our profession has experienced 100 years of successful practice and phenomenal growth. It is still only on the brink, however, of the health science knowledge that can be available from **clinical** study of the neuromusculoskeletal system. And when I say it is available, I really mean available, accessible right at your fingertips with palpation. This is the exciting area of clinical knowledge that Still began to tap. He sensed its clinical significance, applied it

successfully, and prompted our access to it by opening a door.

As a discipline, we are still just on the doorstep. Our attention has concentrated on the importance of manipulation as something to apply, rather than attending to the importance of msk findings as something to be described. If we cannot come to provide our palpable findings with factual descriptors that have a scientific basis in the conduct of physical exam, then we cannot move forward with our professional identity. To aid us, we have the opportunity for improved terminology, physiologic concepts for movement in a mobile system, and for systemic interactions and their relevance to health. In fact, these provide a new opportunity to discover! To report not only what Still was struggling to describe 100 years ago, but now to move on with continuing new clinical knowledge about osteopathic medicine into the 21st century.


As osteopathic students, and eventually as physician DOs, **Be what you are!**

Establish ownership in the discipline of osteopathic medicine. Apply the scientific method to the palpatory exam of the msk system, in your college lab units, in your hospitals, in your clinics, in your office. Participate in discovery. Improve not only your patient's health, improve your discipline, by adding to the clinical knowledge base for osteopathic medicine.

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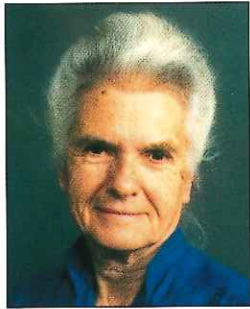


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