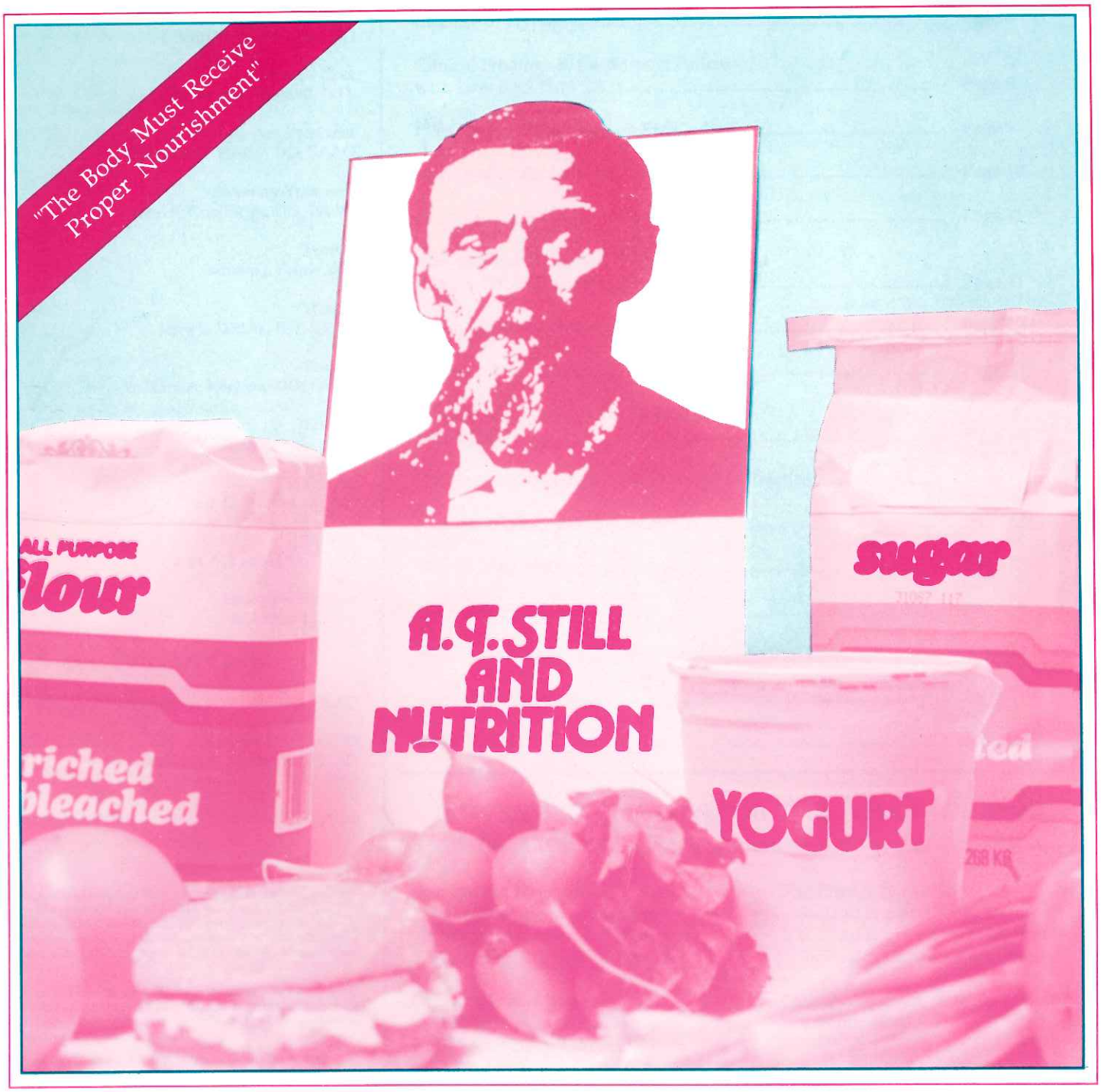
THE AAO
JOURNAL
A Publication of the American Academy of Osteopathy
VOLUME 1 NUMBER 2/SPRING 1991



American Academy of Osteopathy

1127 Mount Vernon Road
P.O. Box 750
Newark, Ohio 43058-0750
(614) 366-7911

The *AAO Journal* is the official quarterly publication of the American Academy of Osteopathy (1127 Mt. Vernon Rd., P.O. Box 750, Newark, Ohio 43058-0750). Third-class postage paid at Newark, Ohio. Postmaster: Send address changes to American Academy of Osteopathy 1127 Mt. Vernon Rd., P.O. Box 750, Newark, Ohio 43058-0750.

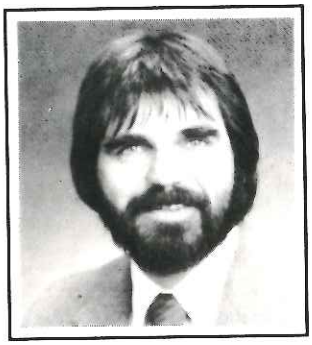
Table of Contents

A Message From The Editor

Raymond J. Hruby, D.O., F.A.A.O.

Welcome to the second issue of the Journal of the AAO! The first issue of the Journal was a great success. We have had a lot of enthusiastic feedback regarding its content and format. It also seemed to inspire a lot of people, because we have had a number of articles submitted for future issues, and we hope to be able to use most of this material.

In this issue, we present information on a number of topics. Our focus is on nutrition, a subject that should be of importance to all osteopathic physicians. Maurice Ramirez, Diana Spillman, and Susan Cross Lipnickey have written an interesting article relating today's nutritional theories with Dr. Still's philosophy, showing once again that A.T. Still was well ahead of his time. This article is nicely complemented by Dr. Wright's case study, showing how important knowledge of nutrition is to the physician.



We also present in this issue Dr. Teitelbaum's article regarding low back pain. This is a timely article, coming on the heels of an excellent Academy Convocation on low back pain.

And speaking of Convocation, those of you who were able to attend know that the program was again well attended and packed with useful information for the practicing osteopathic physician. If you were not able to go to Convocation, you will find a report of some of the Convocation activities within these pages. You should also know that the Convocation presentations were professionally videotaped by Lifeline Medical Communications, and will soon be released in the form of a video journal.

As with any periodical, we will always be looking for input, so I encourage any of you to submit articles for our consideration. We are particularly interested in clinically related articles, and articles that illustrate the art and science of osteopathic practice. This would include essays, philosophical points of view, poetry, or anything else that reflects the day to day life of the osteopathic physician. So, if you have items of interest, or if you ever thought about writing but were afraid to do so, now is the time. In addition, you will be contributing your valuable knowledge and wisdom to the profession.

While the Journal has enjoyed initial success, we hope, of course, to show continued growth and improvement. As always, we would like your feedback, so that we can make every attempt to meet the needs of the readership. Enjoy the season!

Call For Articles

We are looking for physician and student articles on:

- Clinical applications of OMT
- Case studies showing OMT and results
- Poems or personal stories on "Memorable Moments in Medicine"
- Documentation of the success of OMT in relieving:
  - — Bell's palsy
  - — Post operative trauma
  - — Autism
  - — Hyperactivity and others
- Examples of thriving practices which specialize in OMT. Articles should include photos, facts, and figures.

Please send articles typed and double spaced to The American Academy of Osteopathy, PO Box 750, Newark, OH 43058-0750.

Letters to the Editor

Dear Editor:

It was with great excitement that I read the article by Laurie B. Jones entitled "Why the Osteopathic Profession Needs a Triple By-Pass..." in your winter 1991 issue. The reason for my enthusiasm was that this article indicated that the AAO had actually called in a Marketing Consultant to take a broad and objective overview of our current status and future direction.

The osteopathic profession is precariously perched between the old and the new. Granted we have come a long way in recent decades. But the way to our future prosperity is not to linger in shadow but rather to step out into the bright light of the modern world. It is the students and recent graduates who are few in number and who lack financial and political clout who will suffer if the current state of affairs continue.

"Ironically, it is established physicians with successful practices and no student debt and the least motivation for change who control the profession."

My personal belief is that Osteopathic Medicine can take a leading role in the changing face of medicine because of its unique benefits. It is therefore our obligation to increase the reach of our profession by making it easier for our physicians to practice and by making our presence known to more of the general public. For example, the designation D.O. and our insistence on independent exams are anachronisms which may in fact keep our profession independent but slowly strangle it. My opinion is that the designation M.D.O. would be much more reflective of what we actually do and would make us more acceptable to consumers of medical services. Universal exams just makes more sense. Training in osteopathy can easily be made a requirement for the degree. Again it is the new physician, as well as the public, who will benefit most from these changes.

If we are to be healthy we must grow. To do this we must abandon our defensive posture and make our profession more attractive both to those of the general public who may choose to enter the profession itself as future physicians. If we truly believe that Osteopathic medicine is a better brand of medicine, we owe it to the people of the world to make sure that more of them benefit from it.

Sincerely,
Fred E. Fenton, MS I UNECOM

Osteopathic Training Part of Allopathic Residency

Good Samaritan Hospital, the largest family practice training program in Arizona, recently approached E. Carlisle Holland, D.O. about incorporating osteopathic manipulative medicine into their physical medicine and rehabilitation medicine rotation. All 2nd and 3rd year family practice residents will be required to spend time at the Osteopathic Children's Center and Structural Medicine Center observing and participating in diagnosis and treatment of children and adults to improve their understanding of the role of manipulative medicine in health care. The rotation includes exposure to structural examination in differential diagnosis, use of postural x-rays in patient assessment, soft tissue injury documentation and treatment, closed head trauma approaches, the use of manipulation in the elderly, adults, infants and children and conservative management of pain syndromes. This is believed to be the first MD residency program to incorporate osteopathy as a requirement for allopathic family practice training.

The Healers

Who are the joy makers
the life shakers
the breeze senders
the sun lenders
the cleansers

oh-
their flights, their heights
their soaring,
their leaps, their strides
fruits pouring -
lavish, rich, restoring.

They are the joy tenders
the soul menders,
the rain enders.

They touch (not much)
the heart,
but to it they impart
a spray, an array
of day
that makes all night
pass away.

They are the healers
the sun's mirrors
the truth feelers

They send their beam (unseen)
and those who need to lean
are given just the briefest brush
of tenderness - enough to crush
the dragons and to hush
that cry from deep within
that cry that has no sin.

That cry now says... begin.

by Margaret Walsh Royson, D.O.
Albuquerque, New Mexico

OSTEOPATHIC MEDICINE:

A CENTURY OLD PROPHESY OF MODERN HEALTH, NUTRITION AND EXERCISE PRINCIPLES

By Maurice A. Ramirez, Diana M. Spillman, R.D., Ph.D., F.A.C.N., and Susan Cross Lipnickey, Ph.D.

ABSTRACT:

The modern health maintenance and nutrition movement are based upon physiologic precepts which, while contemporary in origin, are foreshadowed in the osteopathic philosophy illuminated by Andrew Taylor Still 100 years ago. The tenets of osteopathy are being rediscovered by the lay public through the wellness movement.

OSTEOPATHIC MEDICINE:
A Century Old Prophesy of Modern Health, Nutrition and Exercise Principles.

In the past decade there has been a physical fitness and health boom. People have been alerted to the importance of good nutrition and exercise by advertisements, professional and lay literature[1]. Americans are interested in what they eat and the types of daily activities in which they participate. Not only have nutritional concerns changed, but people are more interested in how the food they consume affects their bodies' mechanisms.[1] This concern for the body's mechanical operation also extends to a new found concern for the functioning of the neuromusculoskeletal system. The lay public is inundated with information on the inter-relationships of health, immunity and disease with this, the body's largest organ system.

Too often the literature has addressed one facet of health and wellness rather than the inter-relationships which are essential to the maintenance of health. The media often states this "health awareness" is a new phenomenon, but attention to wellness, immunity and the importance of nutrition are the central dogma of osteopathic philosophy.

Andrew Taylor Still listed five principles upon which osteopathic practice is based. Writing in Victorian style, allegory was a mainstay of Dr. Still's works. This use of allegory is a frequent cause of misinterpretation by contemporary commentators. We will explain how osteopathic principles foreshadowed today's nutrition and exercise recommendations as key factors in the maintenance of overall well being.

THE NUTRITION CONCEPT:

This osteopathic principle portrayed Dr. Still's belief that the human body is a self repairing system: *"You will learn that the body is self-creative, self-developing, self-sustaining, self-recuperating, self-propelling, self-adjusting and in doing all these things on its own power, it will use only those things which belong to the realm of foods."* [2]

The first main point to consider is what types of foods to consume for optimal health. While there is no single diet that will work for everyone, the Recommended Dietary Allowances can help individuals construct a healthy daily regimen. These Recommended Dietary Allowances stress a high carbohydrate, low fat diet that draws on fresh, unprocessed foods, and limits salt, sugar, alcohol and caffeine. Dr. Still realized diet should be based on body need, and not on social status as was the standard of his time. While Dr. Still's advice is obvious now, it was a radical statement at the turn of the century: *"Eat three conservative meals a day. Do not be a glutton! You can poison your system with too much food too often and of the wrong kind. Food is for keeping the furnace warm. As the body uses same, it should be replaced."* [2]

The body's nutritional needs are the same whether one participates in exercise or watching television all day. The difference lies in the calories required for aerobic exercise increase because of the amount of energy burned during physical activity.[7, 14] Dr. Still also recognized the danger of non-food diet supplements and warned: *"Nothing is needed but plain, ordinary nourishment."* [2]

During aerobic activity, the body uses carbohydrates as a primary fuel for energy.[6, 11] Carbohydrates are stored in the muscle tissue as glyco-

gen, and converted into the glucose to provide energy to the muscle cells, although, fat and protein can also serve as fuel for muscle activity. This does not occur unless a person has exercised vigorously for a long period[15]. The key point is that carbohydrates supply the body with efficient, quick energy to improve endurance.[6, 7, 11, 12]

A daily diet for someone who is participating in aerobic exercise should consist of an appropriate number of calories to support an elevated activity level. An inadequate number of calories may lead one to become weak during exercise which itself would be counterproductive. Further, the decreased function associated with the calorie deficit could lead to injury. Injury is the structural result of impaired function and the antecedent of further functional defects.

It is recommended that a diet consist of fifty to seventy percent of calories from carbohydrates, ten to fifteen percent from protein and no more than twenty to thirty percent from fat.[6, 12] Unfortunately, the average American diet does not follow these recommendations, being too high in fat and too low in carbohydrates. To get the proper amount of carbohydrates, foods such as breads, cereals, fruits and vegetables should be consumed.[6] With an increased knowledge of the importance of correct calorie consumption and of what a diet should consist, the American public should be able to optimize the quality of their dietary intake.

In addition to knowing which foods to eat, it is necessary to consider when to eat and when to exercise. Many athletes plan their activities around their meals. There are many valid reasons for this,and the aerobic exerciser should consider these reasons and the admonishment of A.T. Still: *"A lesson for man not to eat and drink till the body is so full that no blood vessel can pass from any part of the chest to the abdomen."* [2]

When food enters the stomach, the heart pumps a large quantity of blood to the gut to aid in digestion.[16] This pumping of blood presents no problem while the body is at rest, but this changes if the body starts to exercise. If a person performs vigorous exercise on a full stomach, there is competition for blood flow between the gut and the working muscles. As a result, blood flow shunts to the muscles, digestion halts and a feeling of abdominal bloating and cramping ensues. To make aerobics more pleasant and beneficial it is necessary to eat meals several hours before exercising. This will enable the body to replenish liver glycogen stores and ensure adequate energy reserves are available for exercise.[6, 11]

There are many factors that influence the best timing of eating and exercise.[17] Meal size is important as exercise should begin after a meal has passed through the stomach and upper intestine. If a large meal is consumed it takes three to four hours for the stomach and upper intestine to empty, a small meal only one to two hours to pass.

The composition of the meal affects meal timing.[17] Carbohydrates are the best choice for a before exercise meal.[11] Avoid highly concentrated "energy foods." Eating glucose or sucrose mixtures less than one hour before exercise can trigger an insulin response that quickly lowers the glucose concentration in the blood.[11, 16] A lower blood glucose level rapidly depletes muscle glycogen. One should not eat foods high in fat or protein before aerobic exercise. These foods are digested slowly and remain in the digestive tract for longer periods. In addition, avoid salty foods, high fiber foods and gas producing foods. The fluids consumed before exercise should not contain caffeine which promotes excessive urination or alcohol which impairs physical coordination.

As discussed earlier, carbohydrates play a major role in the body's ability to provide energy for aerobic exercise. Although carbohydrates provide the largest amount of energy, fats as well as proteins also supply energy to the body. There recently have been several reports concerning changes that occur in various aspects of protein metabolism during exercise.[15, 16] These studies have shown that during exercise, amino acids from protein are converted to glucose via gluconeogenic pathways in the liver and muscles. Carbohydrate from food outweighs protein metabolism in the provision of glucose for muscle activity in exercise.[15] This dependence on carbohydrates and the de-emphasis of protein and fat loading in athletics makes it possible for aerobic exercise participants to adhere to vegetarian, or religious diet habits.[6, 18]

Summary:

"Diet, fresh air and exercise have largely aided me in the work of my life". [2]

While Andrew Taylor Still never imagined the impact exercise and nutrition awareness would have on modern American society, this statement makes it obvious that he was aware of the importance of the integration of nutrition and exercise in total health and fitness. Aerobic exercise and sound nutrition each play a significant role in the promotion of health and wellness. However, only when employed concurrently is the maximum benefit achieved. The concept at the heart of all osteopathic thinking further points up the intricate interdependency of body systems and their functions. This fifth osteopathic principle was stated simply and without embellishment whenever Dr. Still spoke of: *"The Unity and Oneness of the Body"* [2]

References on Page 22

Maurice A. Ramirez is an Osteopathic medical student at The University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery in Des Moines, Iowa.

Diana M. Spillman is an Assistant Professor of Nutrition and Food Systems at Miami University in Oxford, Ohio.

Susan Cross Lipnickey is an Assistant Professor of Physical Education at Miami University in Oxford, Ohio.

Insanity Or Hypoglycemia?

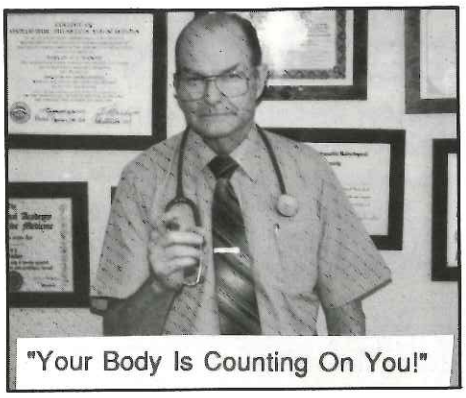
A case history by Harlan O.L. Wright, D.O.

Two years ago a man called the office to talk to me about his wife, age 50. There was obvious anxiety and even a hint of desperation in his voice. He wanted an opinion as to whether or not I could help his wife. He started by saying that I was his last hope. If I could not help her she was going to have to be put in the State Mental Institution.

Betty (not her real name) had always been a very vivacious, outgoing and upbeat personality until approximately three years ago when she began to show signs of fatigue and irritability and having spells of mild depression. This went on for about two years, becoming a little worse all the time. She finally went to see her gynecologist who found she was having "female problems" because of a fibroid uterus and advised that she have a hysterectomy and oophorectomy. The surgery didn't improve her feelings of fatigue and depression as it was thought that it would. She was put on a hormone supplementation which helped for a while. However, Betty's condition gradually deteriorated. Her symptoms began to become more severe and more numerous including complete fatigue, mental confusion, a feeling of tightness and tenseness in her chest, constantly cramping leg muscles, spells of panic and tachycardia, fainting spells and deepening depression. Her gynecologist referred her to an internist who did exhaustive studies on her blood, finding nothing he considered significant. X-rays and complete cardiology studies revealed "mitral valve prolapse". Her symptoms were then assumed to be coming from M.V.P. and the resulting anxiety. She was put on Xanax, Procan S.R., Pamelor and Synthroid. These medications made her even more lethargic and mentally inadequate and she became hallucinatory at times and out of touch with reality. She was then referred to the psychiatric ward of a hospital where several psychiatrists examined her and experimented with other antidepressants etc. Betty's husband was finally told (within hearing of the patient) that she would be put in the State mental institution and that she would finally end up committing suicide!

All of these happenings, in and out of doctors offices and hospitals, occurred over a period of one year post surgery. It was at this point that a family friend, whom I had helped with a similar problem, suggested that he call me.

Betty's husband was told to get copies of all the laboratory work that had been performed and we arranged to see her immediately. When she walked into the office I observed an extremely morose and expressionless woman with very attractive facial features weighing about 130 lbs. She sat at my desk very depressed and withdrawn, displaying very bizarre behavior and obviously not wanting to answer questions. She expressed the feeling that all of her troubles were her own fault and that God



Dr. Wright gives this photo on a refrigerator magnet to his patients.

was punishing her.

Her past dietary history had been one of an average diet with frequent binges on sweets and eating lots of chocolates.

Notable findings on examination revealed a deeply grooved tongue in the center line, white spots on her fingernails, a very irregular heartbeat, several upper thoracic rib lesions and very tender trigger points on both occipityal ridges.

The laboratory findings which her husband brought in were essentially normal WITH ONE VERY NOTABLE EXCEPTION. Her five hour glucose tolerance test was highly abnormal and so typical of a very advanced case of REACTIVE HYPOGLYCEMIA that I could not see how any thinking doctor could dismiss it as unimportant. Fasting blood sugar was a normal 105 mg.%, 1/2 hour 184, 1 hour 168, 2 hour 122, 3 hour 106, 4 hour 82, 5 hour 65. The test should have been continued as the blood sugar was still dropping rapidly, but any further figures would have been of only academic interest as the diagnosis of Reactive Hypoglycemia should have already been made. Such wide variations in blood sugar (or any other of the bodies essential nutrients) cannot be tolerated by nature and severe symptoms can result.

I started treating this patient on June 2, 1989 by putting her on a good nutritious diet of unrefined foods with absolutely no refined sugar or refined flour foods of any kind. She was given specific vitamin and mineral supplementation as needed to correct her obvious deficiencies: Vitamin B complex for her badly fissured tongue, Magnesium for her irregular heart beat, Calcium and Magnesium for her leg cramps, large doses of Niacinamide for her depression and mental confusion, Vitamin C for her bleeding gums, and zinc because of the white spots on her nails. She was also given Osteopathic Manipulative Treatments to stimulate the pancreas and adrenal glands and to correct the numerous thoracic and cervical lesions which were causing much of the discomfort in her chest and head.

On June 5th, Betty was already beginning to show improvement. Her attitude was much improved and she even smiled a time or two. Her leg cramping was also improved. By June 11th she was having no more fainting spells and was beginning to think and communicate clearly. She was smiling a great deal on this visit. On June 22nd Betty was taken off some of her Xanax. On each visit she was given O.M.T. and I.V. vitamin therapy and assurance that she was going to get completely well. By this time I was seeing the patient only every week or so and she continued to make progress. By August 1st she was riding her bicycle and expressing some of her old enthusiasm for life again. On Sept. 7th she had just returned from a vacation in California and was doing extremely well and expressed gratitude for her improvement. By October 31st Betty was off all mind altering drugs including Xanax. I have treated her very little since October of 1989. She still comes in for general health care, but no longer needs treatment as far as her hypoglycemia is concerned. She is again a vibrant and wonderful lady who is thoroughly enjoying life as never before. The only lingering effects of Betty's severe "insanity" are the understandable resentments that her real problem wasn't diagnosed earlier and that she had to go through a year of "hell" before she got help.

COMMENTS:

This is a perfect example of some of the serious problems in the allopathic and osteopathic professions today. We are being taught to depend on high tech methods of diagnosis and then to prescribe drugs which are foreign to the human body, rather than to practice the original precepts of osteopathy. When are we going to start listening to the patient and using our reasoning power and common sense to help people overcome their self induced and doctor induced illness by helping the body to help itself?

Harlan O.L. Wright D.O.
4903 82nd St. Suite #50
Lubbock, Texas 79424

Clinical Findings in the Suspect Patient with Low Back Pain

by David Teitelbaum D.O.
Ft. Worth, Texas

Osteopathic physicians are very well trained to assist the patient in recovery from low back disease and pain. Unfortunately, our training often is lacking when it comes to dealing with the patient who is reluctant to get better. Many of our patients have secondary gain components associated with their low back pain. This can be in many forms, including increased attention, acceptable avoidance of undesirable activities, or, as in cases of workman's compensation and pending litigation, financial gain.

A patient may become suspect by their behavior upon entering the office, during the taking of a history, or during physical examination. The patient may enter the office walking with painful, slow steps, or perhaps leaning heavily on a cane. In the taking of a history, there may be continued insistence on having a spouse or witness corroborate statements. On physical examination, there may be unexpected jerks to denote pain as the spine is examined.

When a patient is suspected of having secondary gain, the following objective tests can be added to the routine low back exam. These tests apply osteopathic principles to detect inconsistencies and confirm clinical suspicions.

Objective Examination of the Suspect Patient with Low Back Pain

With The Patient Standing:

1. Instruct the patient to raise his hands towards the ceiling.
Discussion: This should not cause low back pain, as the lumbar muscles are not engaged. Be suspicious of discomfort or alleged inability to perform this simple test.

2. The physician places his hands on the patient's shoulders and rotates the trunk from side to side.
Discussion: This should not cause low back pain as the trunk will move as a unit, and the lumbar rotators will not be engaged. Again, be suspicious of discomfort.

3. The physician grabs the patient's belt loops or the iliac crests bilaterally and rotates the patient from side to side.
Discussion: This may induce low back pain as the lumbar rotators are engaged. This test is especially useful when used with number 2 above.

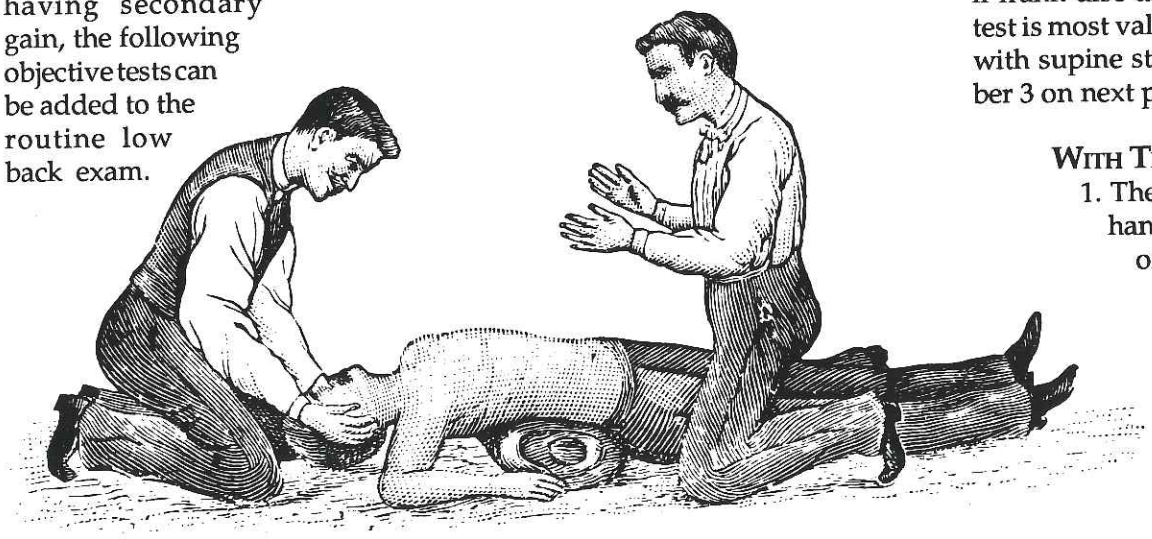
4. Have the patient passively forward and backward bend to the limits of comfort. Note carefully the degrees of motion in both directions. Repeat this test later in the examination.
Discussion: It is difficult for a patient to repeat a fallacious permitted amount of forward or backward bending. Be suspicious of significant variances in range of motion.

With The Patient Seated:

1. Using a reflex hammer, test the patellar reflexes as you normally would. Then, straighten the leg and dorsiflex the foot as if preparing to test the Achilles' reflex from this position.
Discussion: You have brought the patient into the straight leg raise position while providing distraction. As in supine straight leg raise testing, this accomplishes forward bending and should produce acute discomfort if frank disc disease is present. This test is most valuable when combined with supine straight leg raise (number 3 on next page).

With The Patient Supine:

1. The physician places one hand, palm up, under each of the patient's heels. He asks the patient to raise the right leg as high as he can, then return the leg to the table. Repeat on the left.

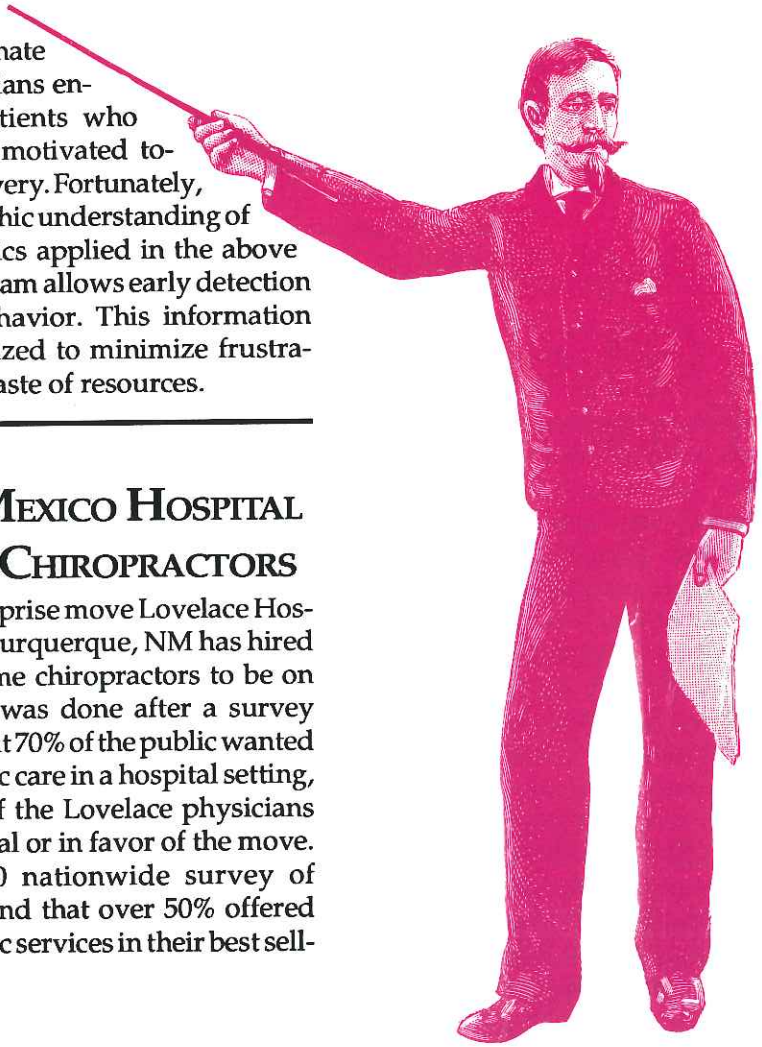


Discussion: This is a test of patient compliance. In a sincere attempt to raise one leg, downward pressure is placed on the opposite heel which is detected by the monitoring hand of the physician. Be suspicious of groaning efforts not accompanied by downward pressure of the opposite heel.

2. The physician places a hand on each of the patient's ilia laterally. The ilia are pressed together.
Discussion: This should cause discomfort only in sacroiliac dysfunction. Be suspicious of alleged pain in the lumber area from this test.

3. The physician performs a supine straight leg raise test.
Discussion: This is correlated with the seated straight leg raise test, (see number 1, seated, above). Results should be the same in both tests. Be suspicious of inconsistencies.

It is unfortunate that physicians encounter patients who are poorly motivated towards recovery. Fortunately, an osteopathic understanding of biomechanics applied in the above low back exam allows early detection of such behavior. This information can be utilized to minimize frustration and waste of resources.



New Mexico Hospital Hires Chiropractors

In a surprise move Lovelace Hospital in Alburquerque, NM has hired two full time chiropractors to be on staff. This was done after a survey showed that 70% of the public wanted chiropractic care in a hospital setting, and 75% of the Lovelace physicians were neutral or in favor of the move.

A 1990 nationwide survey of HMOs found that over 50% offered chiropractic services in their best selling plans.

PPRC and CPT at Odds on EM Coding

The implementation of the Medicare Fee Schedule (MFS) will require changes in the codes physicians used to report their evaluation and management (EM) services. Because the current CPT system is not interpreted uniformly by physicians, the same CPT code may be used for visits that vary substantially in terms of work. Under the MFS, a single relative value will be assigned to each code nationally and this code will apply to physicians in all specialties. For this reason, visit codes must be revised to represent similar resource costs to all who use them.

The PPRC recommends reforming the EM coding system so that codes can be interpreted uniformly by physician and payers, understood by patients, and assigned accurate relative values under a resource-based payment system. The Commission further recommends that the simplest coding system which accomplishes this task should be adopted. It is this requirement that has put the American Medical Association's CPT panel at odds with PPRC.

The PPRC system uses:
1) twelve classes of codes to distinguish visits that differ in terms of effort or practice costs; 2) A uniform set of levels of service (reflecting the complexity of medical decision making, the extent of which EM services provided, and typical physician encounter time) to differentiate visits in all classes; and 3) a special modifier for visits with patients who have communication barriers, disabling cognitive or physical impairment, or an unusual need for counseling or coordination of care.

Meanwhile, the CPT panel and the Health Care Financing Administration (HCFA) are pilot testing the proposed CPT recommendation on EM coding despite its participation in the PPRC consensus panel which made recommendation to the Commission. The CPT system is much more complex because the number, content descriptors and times in the levels of service differ for each class of visit. The Commission maintains that such complexity is not necessary to develop the levels of service that are applicable to different classes of visits and urges the AMA to refine its system to meet the needs of the relative value scale.

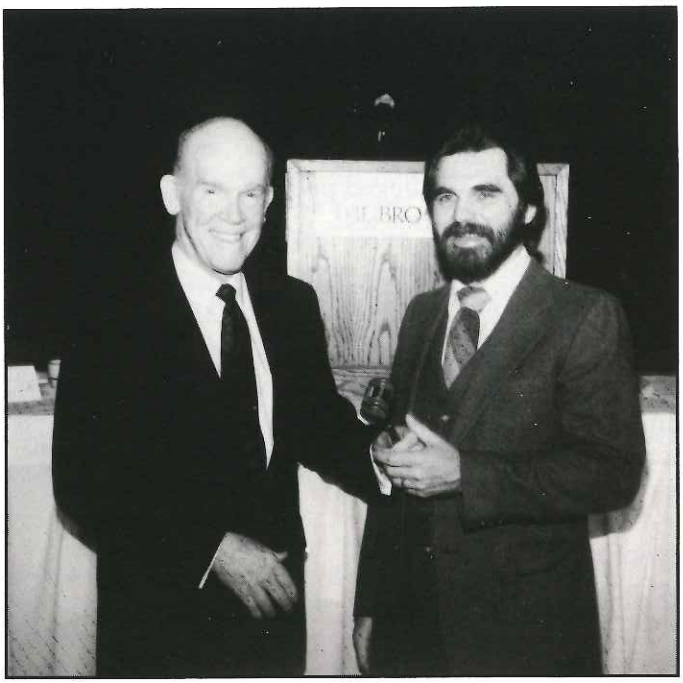
J. Scott Heatherington, D.O.
New AAO President

J. Scott Heatherington, D.O., Lake Oswego, Oregon, is the new President of the American Academy of Osteopathy. He was voted as President-Elect during the Academy's Annual Membership Business Meeting at The Westin Hotel in Cincinnati, Ohio on March 21,1990. Dr. Heatherington's term as AAO President began upon taking the oath of office administered by former President, Raymond J. Hruby, D.O., F.A.A.O. Installation ceremonies were conducted during the Academy's Banquet at the International Center of The Broadmoor Hotel in Colorado Springs on March 22, 1991.

Dr. Heatherington is a 1944 graduate of the Des Moines Still College of Osteopathy and has been an active participant in the osteopathic profession ever since. Some of his past credits include: Dean and Professor of Osteopathic Medicine at the Oklahoma College of Osteopathic Medicine and Surgery in Tulsa; Medical Director and Director of Medical Education at the Oklahoma Osteopathic Hospital; Chief of Staff, member and chairman of the Board of Governors and Director of Osteopathic Services at Eastmoreland Osteopathic Hospital in Portland, Oregon.

This will be Dr. Heatherington's second term as President of the American Academy of Osteopathy. His first term was from 1979-1980. He served the Academy well through the years and had Life Membership bestowed upon him in 1980.

Dr. Heatherington and his wife reside in Lake Oswego, Oregon.



New AAO Pres. J. Scott Heatherington, receiving the President's Gavel from outgoing Pres. Raymond J. Hruby.

Judith A. O'Connell, D.O.
AAO President-Elect

Judith A. O'Connell, D.O. of Dayton, Ohio, is the new President-Elect of the American Academy of Osteopathy. She was elected to this office during the Academy's Annual membership Business Meeting at The Broadmoor Hotel in Colorado Springs, Colorado on March 20, 1991. She will assume the office of President during the Academy's Annual Convocation in Kansas City in March 1992.

Dr. O'Connell is a 1980 graduate of the Chicago College of Osteopathic Medicine and served her internship at Grandview Hospital in Dayton. She is currently in a private practice in Dayton that is limited to osteopathic manipulative medicine. Some of her credits include: Director of the Department of Osteopathic Manipulative Medicine at Grandview and Southview Hospitals; Chairperson of the Evaluation of Osteopathic Principles Committee at Grandview Hospital, and Assistant Clinical Professor at OU-COM. She also served as Chairperson of the Academy program during the 1990 AOA Convention in Las Vegas. Her "mock trial" concept was well received by those attending and demonstrated how to be an effective witness and survive the physician/attorney encounter.

In addition to the AAO, Dr. O'Connell is a member of other professional societies including the AOA, Ohio Osteopathic Association, The Cranial Academy, The American Osteopathic Academy of Sports Medicine, and the Dayton District Academy of Osteopathic Medicine.

Dr. O'Connell, her husband and two daughters reside in Dayton, Ohio.

Medicare OMT Reimbursement

by Don Self, Medical Consultants of Texas

Too many physicians billing for Osteopathic Manipulative Therapy are using less than desirable codes for these services. National Level II HCPCS codes M0702 through M0730 are for OMT by physician. CPT codes 97260 and 97261 are for manipulation by physician. If you use both codes (M0702 & 97260) on a Medicare claim, Medicare will use the one that pays you the least. As an example, in Texas, they compare as follows (following are averages):

CODE	DESCRIPTION	LC	APPRVD
M0702	OMT up to 2 Regions	$42	$33
M0704	OMT up to 4 Regions	$84	$71
M0706	OMT up to 6 Regions	$125	$106
97260	Manipulation - 1st Area	$18	$15
97261	Manip. Ea. Addt'l Area	$15	$13

Let's say this is your profile (JUST AN EXAMPLE), and you do OMT to three regions on a Medicare patient, and you are not accepting assignment: You would make $84 using code 97261. If you were accepting assignment, you would make $71 using M0704 or $41 using 97260/97261. Private insurance carriers do not recognize Level II HCPCS codes, so you have no choice but to use codes 97260 and 97261 for them. With Medicare you have a choice. In Texas, you usually see a much larger reimbursement by using the Level II codes.

One client in Florida has an approved amount of $10.10 for code M0704, and $10.50 for M0706, while his approved amounts for code 97260 is $18.70 and $12.90 for code 97261. It is obviously better for him to use the CPT codes.

Codes vary from region to region. If you have a question about coding, call me at 1-214-839-7045.

Rural Access is High on Physician Payment Review Commission's Agenda

The Commission identifies improving rural access to health care as an important agenda item following implementation of the Medicare Fee Schedule. Although each rural community typically encounters its own unique set of problems, interrelated circumstances broadly characterize rural health care delivery and often urban underserved areas as well.

It is in this context that the Commission discusses broad options to address these unique concerns and establishes a framework for further research and recommendations in the coming year. The Commission links the shortage of health personnel to the type of training received, financial and other disincentives to offset practicing in a remote area, and persistent rural hospital closures. PPRC makes clear that geographic adjustment factors (GAFs) can account for the variation in input prices between rural and urban areas without bias against rural practitioners. PPRC notes however, that GAFs cannot account for the extra costs incurred by rural practices due to underutilization of equipment.

The Commission recommends, therefore, that the use of alternative volume assumptions may be necessary in geographic areas where an efficient use of equipment is not consistent with access to care. The Commission notes that the GAF itself is not enough to increase the supply of physicians in rural areas and recommends the use of a "bonus payment" as a more appropriate mechanism to address this problem.

The Commission further notes that the rural access problem may be improved through the Commission's other work such as recommendation on payment under Medicaid and payment for graduate medical education. It sets the need to examine the health care delivery for the underserved high on the agenda for the coming year and notes that both the rural and urban underserved have unique problems which must be addressed.

"Please don't let them change the rules before I finish this claim!"

INFANT HEAD SHAPING

Submitted by Dr. Gary L. Ostrow, D.O.
Excerpt from JAMA, Vol 265, No. 9, March 6, 1991

QUESTION

It has recently come to my attention that in some cultures mothers sometimes practice what is referred to as "head shaping." According to my informant, when a newborn baby has a head shape that is considered unattractive, the mother may improve it with selective manual pressure on the head during the first year of life. Is this practice common? Have there been associated reported injuries to the skull or brain?
M.D., Florida

ANSWER

Head shaping or head molding, otherwise known in the plastic surgical literature as "nonoperative cranioplasty," dates back to very ancient times and has enjoyed wide acceptance in many old cultures. [1] International cranial deformation or reformation, producing craniofacial bony architectural modification, was widely practiced in various ancient cultures of North and South America, Asia, Europe, and Africa. [1] Some of these practices date back to more than 2000 BC in Crete, Cyprus, and ancient Egypt.[2] In some cultures, it was employed to achieve distinction between families or to identify oneself with particular populations.

It was used by the Polynesians in Tahiti,[3] by the Incan royalty of Peru[4] and the Hawaiian alii, or royalty.[5] Among the Incans, certain nobles were permitted to shape the heads of their children similar to those of the royal family.[6] In their writings, Hippocrates and Pliny both mentioned the practice of female childhood head compression among the Greek aristocracy.[1] The practice in Europe extended from Western Asia across Eastern Europe through the Crimea, the Balkans, Hungary, Austria, West Germany, Switzerland, Italy and France.[6] In addition to Peru, it also had widespread appeal in many South American countries including northern Chile, northwest Argentina, Ecuador, and Columbia.[6] In parts of Mexico and in North America, Indians also practiced the art of head shaping. Among these, the Maya of Central America, the ancient Apache and Navajos, and the modern tribes of the Pueblo, Mohave, and Yuma all practiced head shaping.

The range of intentional skull deformation (reformation) is quite large, varying from one extreme that produced grotesque cranial distortions to mild or minor deformations. Some of the extreme forms can be associated, albeit rarely, with significant problems such as proptosis,[2] epilepsy,[2] mental retardation,[1] and even death.[1] The vast majority of head shaping produces no significant problems and appears to be safe.[1,6] Anthropologists have attempted to classify these deformations.[1] The French anthropologist Gosse[1] described 16 species of deformations, which he classified into five different types: (1) vertico-occipital or simple occipital, (2) fronto-occipital, (3) frontal, (4) lambdoid, and (5) annular. These various types produce differently shaped heads with multiple variations.

In most cultures, head shaping or molding began within a few days of birth,[7] employing external forces and contraptions to conform the head to a desired shape. In some cultures, it was continued for only the first 3 months[5] and in others for much longer.

Head shaping or molding appears to be a safe practice since it does not appear to change cranial vault weight or volume or intellectual capacity.[6] Indeed some plastic surgeons have, in fact, considered the use of techniques similar to head shaping or molding as a valuable tool in the correction of certain craniofacial abnormalities.[8]

F.O. Adebonojo, MD
East Tennessee State University
Johnson City

1. Tropinard P. *Anthropology*. Philadelphia, Pa: JB Lipponcott; 1878.
2. Henshen P. *The Human Skull: A Cultural History*. New York, NY: Praeger Publishers; 1966.
3. Marshall DS, Snow CE. An evaluation of Polynesian Craniology. *Am J Phys Anthropol*. 1956;13:405-427.
4. McGibbon W, Artificially deformed skulls with social reference to the temporal bone and its tympanic portion. *Laryngoscope (St Louis)*. 1912;22:1165-1189.
5. Schendel SA. Hawaiian head molding, Plastic Reconstr Surg. 1986;78:267.
6. Shapiro HL. A correction for artificial deformation for skulls. In: *Anthropological Papers in the Museum of Natural History*. New York, NY: American Museum of Natural History; 1928;30. Part 1.
7. Nichter LS, Parsing, JA, Horowitz JH, et al. External cranloplasty: historical perspectives. *Plastic Reconstr Surg*. 1986;77:325-332.
8. Epstein F, Hochwald GM, Ransohoff J. Neonatal hydrocephalus treated by compressive head wrapping. *Lancet*. 1973;1:634-636.

WE NEED MORE VISITING CLINICIANS AND SCHOLARS

If anyone is interested in applying for the Visiting Clinician and Visiting Scholar programs, please contact College Assistance Committee at the Academy office.

LETTERS TO A.T. STILL

Dear Dr. Still,

Not long ago I wrote to you regarding the discussions we modern day osteopathic physicians have regarding the various types of manipulative techniques that have been developed. You, of course, did not talk much about technique in your writings, but focused so much more on concepts. You especially emphasized the importance in knowing very thoroughly the anatomy and physiology of the human body, and how technique would flow naturally from this knowledge. If one knew the normal, one would recognize the abnormal, and would immediately know what would have to be done structurally in order to restore optimum function.

Well, I re-read something very interesting the other day, and I thought you should know how much it impressed me. I was perusing once again Dr. Hildreth"s book, The Lengthening Shadow of Dr. A.T. Still, and I came upon the passage (pp. 180-183) wherein you described how you visualized the body when evaluating a patient. You said that first you observed the skeleton, since that was the foundation upon which all other body structures were built. You then looked at the ligaments, and then the muscles. Your next step was to see in your mind's eye the nervous system, first observing the brain and spinal chord, and then the sympathetic system. The sympathetics, you said, controlled "... the functions of the internal organs, the circulation of body fluids, and nutrition of the various body parts."

Then, you said, you observe the arterial system, which carries oxygen and nutrients to all cells of the body, the venous system, which removes the waste products of cellular metabolism, and the lymphatics, which have to do with "the mechanism of nutrition, absorption and protection of cells from harmful poisons and bacteria." Lastly, you observed the glandular system and how it affects the individual patient.

Andrew Taylor Still

As I read this passage, I was struck by the fact that you were not focusing on a disease or on viscera, but on the supportive systems of the body - the musculoskeletal, circulatory and nervous systems. You were trying to find out how these systems had been disturbed such that altered visceral function resulted. It brought to mind your viewpoint that diseases are not really diseases, but are the effects of a more ultimate cause. This certainly illustrated the importance of the structural systems of the body in health and disease. Just think of it! The ability to go beyond the usual litany of signs and symptoms, and to observe, palpate and treat the very causes of so many human ailments. That is truly the difference an osteopathic physician can make.

I certainly hope to never forget to share the principles of osteopathy with every patient I see. It helps to be able to read the many ways you described and illustrated these principles, so that we could understand and apply them, too.

Your ongoing student,
Raymond J. Hruby, D.O., F.A.A.O.

A. T. Still.

1828-1917

- Was the first to identify the human immune system and develop a system for stimulating it naturally.
- Was the first to welcome women and minorities into medical school.
- Predicted that this nation would have a major drug addiction problem within the century if physicians did not quit over-prescribing addictive drugs.
- Warned that women were far too often the victims of needless surgeries.
- Believed that physicians should study prevention as well as cure.
- Believed that disease in one body part affects all other parts.

Break Ranks. Branch Out. Be Bold and Boil it Down.

by Laurie B. Jones, Marketing Consultant

Breaking ranks is so important. Without it we would not have art, creativity, this country or this profession. Have the courage to step out from the crowd.

The story that received perhaps the greatest response at the A.A.O. Annual Convocation was my interpretation of David and Goliath. David, a simple shepherd boy, goes to take lunch to his brothers who are on the front lines with King Saul's army. King Saul's army unfortunately, is doing more trembling than conquering, as daily they are greeted by the shadow of the very unfriendly, and very giant Goliath. "He eats Israelites for breakfast", they say, so no one wants to go forth to meet him.

David, having been tending the sheep, is unaware of these sayings (at first) but is highly incensed by this attack on his people. "Doesn't the know who we are?" he exclaims. "Aren't we the people God brought out of Egypt? Why are we trembling in our tents? Let's take this giant on!" "No way, Jose!" say the troops. Especially David's brothers.

The one thing that really jumped out at me about this story is that it was David's brothers who tried to keep him from battle. Not out of concern for his well being I might add - but out of their own egos/insecurities. "Who do you think you are?" they said. "Go back to the sheep where you belong!" "You're just in it for the glory," they said. And as you can imagine this led to quite a scuffle. But it also came to King Saul's attention. Here at last was someone willing to take on the giant. So Saul says, "Bring him here." Figuring he has nothing to lose, but not wanting it to be too one-sided, Saul says "Well if you must go forth - at least wear my armor." So David puts the armor on and finds he can hardly walk - much less fight. "Nope," he says, "thank you. I'll just use the resources I have - throw in some of my experience (defending sheep) and trust that God will help me do what I can do." So, out he goes with five stones. (Can you imagine having "backup" stones against Goliath? I mean, you hit him with one stone and just nick him? He's really going to be mad!). Anyway David takes the resources he's "examined", and "educated", and "enlisted" them in a mighty way.

And the Giant falls. One well-aimed stone did it all.

I love and use this story a lot because it illustrates so many of the successful steps to marketing. David had the courage to break ranks and the rest is history.

Are you following the crowd? Or are you willing to take a leadership role and help defend and set new standards for the profession?

Branch Out.

List three ways you can extend yourself and your services to others. Does it mean extending office hours - adding a new partner - getting another location - opening up new clinics?

People who are successful have branched out. Several hospitals in California are experimenting with shopping mall locations for "check ups". Chiropractors offices can often be found in shopping malls. Go where the people are. Don't expect them to always come to you. Visualize the people who need your services. How do you reach them in newer, better ways?

Boil It Down.

One of the keys to success is also knowing and acting on your core values... not over-extending yourself or taking someone else's armor. Do you have a specialty that you truly love? Do you wish that you were doing more of one thing and less of another? Perhaps your need is to simplify - to be "truer" to yourself.

Go for your IDEAL once you've boiled it down. Trust that you can have/create what you really want. Maybe you want to specialize in cranial manipulation. Maybe you want to limit your practice to children. Maybe what you want to do is teach. Be true to what you love. Boil it down.

For more information call
The Jones Group
at (619) 296-6563.

COURSE PRESENTED ON PITFALLS TO AVOID IN PRACTICE

Two physicians launched a course in how to avoid the financial pitfalls in a medical practice titled, "Ripe For Plucking," recently presented at the AAO Convocation in Colorado Springs.

Dr. Eric Dolgin and Dr. Stephen Davidson, who admittedly were naive starting out in practice, presented the sum total of their 20-years experience in a book of the same title, "Ripe for Plucking," which was reviewed in the course.

Subtitled "A D.O.'s Survival Guide", the manual contains an "administrative arsenal" of letters, forms and general information (77 pages) that enables the physician to address problems unique and not-so unique to the osteopathic profession:

- Attorneys who refuse to pay for services requested by their office;
- Insurance companies that deny a patient's claim and code the Osteopathic procedure as "chiropractic" or "physical therapy";
- A three-letter system established for non-paying patients;
- How to empower yourself in a deposition or in trial;
- Procedures established to run an efficient office (i.e. office policy form, office work procedures, telephone messages, meetings, billing, travel expense voucher, etc.'
- And Forms: MVA Questionnaire, MVA (Accident) Report, Release A Difficult Patient, Medical Report, (requested by attorney), Patient Form, etc.

The 77-page book sold out at the first course meeting, and more than 85 medical students and physicians attended the course.

As indicated by the comments below, a course on this subject matter was long overdue.

- "This course is an absolute must for anyone who wants to avoid common problems that will occur in starting and running a practice. This was the best spent time of the convocation."
- "I won't have to reinvent the wheel. Thanks."
- "Very practical & pertinent speakers were instructive and entertaining."
- "This is the only practical course that I have experienced in my education career. It has succeeded in reducing my naive views of a future medical practice to a realistic perspective of this profession with its medical and legal problems."

More than one questionnaire carried the same comment from participants suggesting Dr. Davidson and Dr. Dolgin take the course to the Osteopathic Schools to teach in the 4th year.

For more information call Practical Publications at 1-800-359-7772.

The American Academy of Osteopathy New Members

(August 1990 - May 1991)

Daniel M. Allen, D.O.
Buffalo, NY
Adam L. Alpers, D.O.
Orlando, FL
Rebecca J. Anderson, D.O.
Indianapolis, IN
Adrienne E. Apatoczky, D.O.
Allentown, PA
Richard L. Aptaker, D.O.
Chicago, IL
Mary F. Asterita, D.O.
Virginia Beach, VA
John Evan Balmer, Jr., D.O.
Harrisburg, PA
Randy B. Barnett, D.O.
Philadelphia, PA
Lonette Bebensee, D.O.
Grosse Pointe Woods, MI
John R. Behm, D.O.
Williamston, MI
David J. Bennett, D.O.
Weirton, WV
David John, Bennett, D.O.
Weirton, WV
Sandra M. Parsons Berglund, D.O.
Middleburg Heights, OH
Michelle D. House Berry, D.O.
Boerne, TX
Tina M. Black, D.O.
Warren, OH
Mary Ann Block, D.O.
Fort Worth, TX
Stephen C. Bloom, D.O.
E. Grand Rapids, MI
Gregory P. Bloxdorf, D.O.
Erie, PA
Carrie L. Bolander, D.O.
Traverse City, MI
Billy G. Boldon, D.O.
Clayton, OH
John Frederick Bosi, D.O.
Philadelphia, PA
William E. Bowles, D.O.
Canton, OH
May-Eileen A. Bue, D.O.
Sterling Heights, MI
Kelley A. Burnett, D.O.
Muskegon, MI
John D. Capobianco, D.O.
Glen Cove, NY
Jane E. Carreiro, D.O.
Waterville, ME
Michelle I. Cervin, D.O.
Muskegon, MI
Liz Chapek, D.O.
Dallas, TX
Marc J. Chernoff, D.O.
Philadelphia, PA
Mary Justine Clark, D.O.
Erie, PA
Sandra A. Collis, D.O.
Mt. Clemens, MI
Louis J. Conte, D.O.
Batonne, NJ
Kimberly J. Couri, D.O.
Chicago, IL
Jonathan Crane, D.O.
Floral Park, NY
Tamara E. Crowell, D.O.
Pittsburg, KS
Erick Charles De Rocher, D.O.
Moore, OK
Corin DeChirico, D.O.
Mattituck, NY
Brian F. Degenhardt, D.O.
Dayton, OH
Deanna M. DelPrete, D.O.
Smithtown, NY
Franklin D. Demint, D.O.
Pinellas Park, FL

Michael G. Dempsey, D.O.
New York, NY
Larry Allen Derksen, D.O.
Wichita, KS
Jane M. Derrig, D.O.
Lakewood, NJ
Jerome A. Dixon, D.O.
Columbus, OH
Michael D. Dorning, D.O.
Western Springs, IL
Dennis J. Dowling, D.O.
Old Westbury, NY
Lisa M. Ducker, D.O.
Levittown, PA
Jeremy Dzen, D.O.
York, PA
Guy Tillen Easterling, D.O.
Niagara Falls, NY
Rolando M. Estupigan, D.O.
Oak Park, MI
Hugh M. Ettlinger, D.O.
Atlantic Beach, NY
Colette J. Feeney, D.O.
Lancaster, PA
Rosemary Feitis, D.O.
New York, NY
Roberta L. Fennig, D.O.
El Paso, TX
T. Kevin Finley, D.O.
Utica, NY
Michelle Fiorillo, D.O.
Winter Park, FL
Roderick Ja-David Flowers, D.O.
Tucson, AZ
Aline G. Fournier, D.O.
San Diego, CA
Gloria W. Freundlich, D.O.
Chatsworth, GA
Alan Philip Gegenheimer, D.O.
Virginia Beach, VA
David M. George, D.O.
Moscow, PA
Robert N. Gerstman, D.O.
Langhorne, PA
Lisa M. Gilles, D.O.
Rochester, MN
Douglas C. Ginas, D.O.
Bethlehem, PA
Steven F. Gitler, D.O.
Philadelphia, PA
Barbara Gordon, D.O.
Flushing, NY
Mark S. Grajcar, D.O.
Tacoma, WA
Mark Allen Gray, D.O.
Fort Worth, TX
Cynthia K. Hamilton, D.O.
Tacoma, WA
Rebecca M. Hanigosky, D.O.
Sharon, PA
Mark J. Hanna, D.O.
Merrionette Park, IL
Gerald R. Harris, D.O.
Fort Worth, TX
Marianne Herr-Paul, D.O.
Lewisburg, WV
Harold N. Hollander, D.O.
Grand Rapids, MI
David R. Hooks, D.O.
Broken Arrow, OK
Michael A. Horn, D.O.
Kirksville, MO
Peter G. Ilowite, D.O.
New York, NY
Gary Dewayne James, D.O.
Cadiz, KY
Christine Janouschek, D.O.
Monee, IL
John H. Juhl, D.O.
Highland Park, NY

Edward J. Jurkovic, D.O.
Oak Forest, IL
Charles J. Kaczey, D.O.
Duncansville, PA
Keith W. Kale, D.O.
Jefferson City, MO
Marc A. Kates, D.O.
Phoenix, AZ
Arlene M. Kellman, D.O.
Greeley, CO
Jerry L. Kellogg, D.O.
Orange Park, FL
Allen L. Kennedy, D.O.
Flint, MI
Steven Monte Kernerman, D.O.
Livonia, MI
Margaret R. Keyes, D.O.
Linwood, NJ
Trent A. Kirschstein, D.O.
Tulsa, OK
Michele M. Knapp, D.O.
East Waterboro, ME
James A. Kneebone, D.O.
Biddeford, ME
Lillie M. Kornreich, D.O.
Washington, DC
H. Jerome Koser, D.O.
Clearwater, FL
Rita A. Koshinski, D.O.
Norristown, PA
John Bennett Kurish, D.O.
Colorado Springs, CO
Gary A. La Polla, D.O.
Franklin Square, NY
Melissa M. Lantz, D.O.
Tenafly, NJ
Emil P. Lesho, D.O.
White Haven, PA
David Liao, D.O.
Mount Clemens, MI
Lawrence M. Littell, D.O.
Ontario, CA
Sharon G. Little, D.O.
Glenpool, OK
Kim Sing Lo, D.O.
Kirksville, MO
Edward G. Loniewski, D.O.
Redford, MI
Alison E. MacDonald, D.O.
Philadelphia, PA
Charles D. Manter, D.O.
Fort Worth, TX
Donald, C. Manuele, D.O.
Portland, OR
Christine M. Marcotte, D.O.
South Holland, IL
Francis J. Martinez, Jr., D.O.
Philadelphia, PA
Christine M. McClusky, D.O.
Grosse Pointe, MI
Susan R. McIntire-Hull, D.O.
Kirksville, MO
Gregory C. McKernan, D.O.
Portland, ME
Stephen L. McKernan, D.O.
Modesto, CA
Kay Lynn L. McLaughlin, D.O.
Lansing, MI
Heidi, A. McNulty, D.O.
San Jose, CA
Michael M. Meador, D.O.
Princeton, WV
Patricia K. Merlo, D.O.
Whitehall, PA
Mary Ann Mikus, D.O.
Des Moines, IA
Vincent J. Mirarchi, D.O.
Huntington Beach, CA
Judith A. Moore, D.O.
Alta Loma, CA

Faramarz Movaghamia, D.O.
Marietta, GA
James W. Nabers, Jr., D.O.
Red Bay, AL
Lois R. Miska, D.O.
Pontiac, MI
Constance E. Noel, D.O.
Madison Heights, MI
Jan A. Olenginski, Jr., D.O.
Plymouth Meeting, PA
John Mikhail Olson, D.O.
Mt. Vernon, IL
Patrick F. Para, D.O.
Chicago, IL
Joe D. Patton, D.O.
Holt, MI
Frank A. Paul, D.O.
Mt. Clemens, MI
Elizabeth Pepe-Sampey, D.O.
DeLeon Springs, FL
J. Thomas Pericles, D.O.
Cherry Hill, NJ
Eric Scott Perry, D.O.
Woodland Hills, CA
Anthony V. Perry, Jr., D.O.
Canton, OH
Timothy A. Piontkowski, D.O.
Lapeer, MI
Keith Pitchford, D.O.
Lansing, IL
Cynthia Lou Poff, D.O.
Indianapolis, IN
Barbara Ann Polstein, D.O.
Mountville, PA
Christopher M. Posey, Sr., D.O.
South Euclid, OH
Marita R. Powell, D.O.
Conklin, NY
James N. Priola, D.O.
Youngstown, OH
Stuart L. Pyatt, D.O.
Troy, MO
Deborah Elaine Pyne, D.O.
Plano, TX
David K. Ramkin, D.O.
Kingsport, TN
M. Tamarin Ring, D.O.
Portland, OR
Hallie J. Robbins, D.O.
Northville, MI
Kenneth C. Roberts, D.O.
Tulsa, OK
Luis Rodriguez, D.O.
Hamilton, OH
Laura M. Rosch, D.O.
Chicago, IL
Anthony M. Ruffa, D.O.
Erie, PA
Howard J. Sadinsky, D.O.
Portsmouth, VA
Timothy J. Sanders, D.O.
Berkley, IL
Paula D. Scariati, D.O.
N. Lindenhurst, NY
Elena L. Schifando, D.O.
Des Moines, IA
Kathryn A. Schmaltz, D.O.
Dayton, OH
Michael Schreiber, D.O.
W. Los Angeles, CA
Craig Ivan Schwartz, D.O.
Farmington Hills, MI
John P. Schwegmann, D.O.
Blue Ash, OH
Eileen A. Schweickert, D.O.
Portland, OR
Phillip S. Scott, D.O.
Centerville, OH
Jeffrey S. Sears, D.O.
Oak Park, MI

Michael G. Shell, D.O.
Tulsa, OK
William S. Sightler, D.O.
Grayson, GA
Robin G. Simon, D.O.
Warren, MI
Todd Simon, D.O.
Langhorne, PA
Frank Simoncini, D.O.
Grosse Point Park, MI
Lillian Somner, D.O.
Brooklyn, NY
Kreig A. Spahn, D.O.
Canton, OH
Steven A. Stein, D.O.
Clementon, NJ
Stephan Stellmacher, D.O.
Mount Laurel, NJ
Scott T. Stoll, D.O.
Fort Worth, TX
Gregory A. Stone, D.O.
Upland, CA
Teresa L. Such-Nelbar, D.O.
Harmony, PA
Benjamin M. Sucher, D.O.
Paradise Valley, AZ
Charlene Tobin, D.O.
Twin Lake, MI
Catherine Valente, D.O.
Elmhurst, IL
Greggory S. Volk, D.O.
Dayton, OH
Mark H. Waddell, D.O.
Clifton Forge, VA
Mancel W. Wakham, D.O.
Lewisburg, WV
J. S. Walker, D.O.
Dix Hills, NY
Edward J. Walko, D.O.
Chicago, IL
Ramona M. Wallace-Brockmyre D.O.
Grosse Ile, MI
W. R. Christopher Wallis, D.O.
Columbus, OH
Michael J. Warner, D.O.
Atlantic City, NJ
Nita B. Weber, D.O.
Flint, MI
Kevin A. Weeks, D.O.
El Paso, TX
Jerrold Weiner, D.O.
Westland, MI
Steven I. Weisberger, D.O.
Jonesport, ME
Gehred D. Wetzel, D.O.
Orefield, PA
Edward A. White, D.O.
Princeton, IN
Andrew J. Wren, D.O.
N. Charleston, SC
Lorah L. Wright, D.O.
Traverse City, MI
Jane J. Xenos, D.O.
Orange, CA
Rajiv L. Yadava, D.O.
Fairview Heights, IL
Daniel Yakima, D.O.
Lincoln Park, MI
Stephen J. Yanoshak, D.O.
Philadelphia, PA
Marc. S. Zipper, D.O.
Noblesville, IN

Convocation Highlights

Wine & Cheese Reception

Tuesday, March 19th, the Academy hosted a Wine and Cheese Reception in Spec's Spot. This event is extremely popular with our membership as it gives everyone a chance to socialize before the hectic pace of the program begins. *The Faculty Dinner* was held earlier in the evening in appreciation of those speakers lending their expertise to the Convocation program.

The Colorado Springs Osteopathic Foundation hosted a reception on Wednesday, March 20th and the *CCOM Alumni Association* on Thursday, March 21st. Both were well attended and we appreciate the courtesy expressed to Academy members by both groups. The *National Osteopathic Women Physicians Association* presented a workshop on communication skills on Friday, March 22nd.

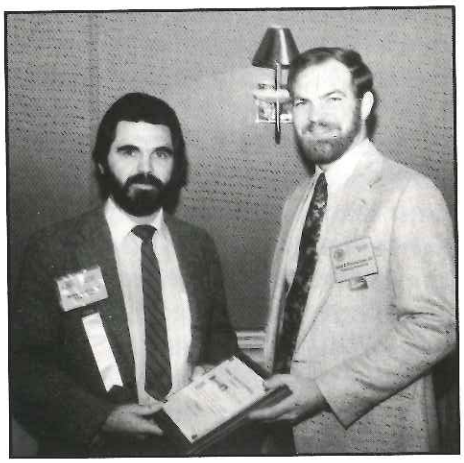
The 1991 Convocation was held at The Broadmoor Hotel in Colorado Springs, Colorado, located at the base of the majestic Rocky Mountains. The Broadmoor is considered "home" by many members of the Academy, as Convocation was held there sixteen years before changing location in 1986. There was some discussion held about returning to The Broadmoor more often than once every three years. More about this at a later date.

Society of Belgian Osteopaths Jean-Jacques DeBroux, AAO Pres. J. Scott Heatherington, Past Pres. Ray Hruby, Pres. Society of Belgian Osteopaths, Willy Vandenschrick, AAO Exec. Dir. Richard Dyson pose after banquet.

Big thanks to Jack Gage and Karen Straub and the remainder of the able staff for going out of their way to make sure things ran smoothly. A job well done, as always!

Convocation Banquet

Dr. Herbert Yates gave the Invocation, after which Academy President, Raymond J. Hruby, introduced the distinguished guests seated at the head table: Boyd R. Buser, Convocation Program Chairman, J. Scott Heatherington, AAO President-Elect, and his wife, Gerri; Mitchell Kasovac, AOA President; George Pasquarello, incoming UAAO Council Chairman and Joe Ruane, outgoing UAAO Council Chairman.



Walter C. Ehrenfeuchter receiving his fellowship plaque from AAO Pres. Raymond J. Hruby.

Walter C. Ehrenfeuchter, D.O., F.A.A.O., received his certificate of Earned Fellowship from Dr. Hruby. Dr. Ehrenfeuchter is the last physician that will receive this particular certificate, as it was issued under the old Fellowship Board.

Dr. Hruby presented Nicholas S. Nicholas, D.O., F.A.A.O., with the 1991 Andrew Taylor Still Medallion of Honor in recognition of his loyalty and many contributions to the osteopathic profession and the American Academy of Osteopathy. Dr. Nicholas graduated from KCOM in 1939 and has been a member of the Academy since 1966. In 1972, he received his Earned Fellowship and in 1978 received Life Membership in the Academy. He was a Professor and Chairman of the Department of Osteopathic Principles and Practice at the Philadelphia College of Osteopathic Medicine until his retirement on July 1, 1987.

Nicholas S. Nicholas receiving the 1991 Andrew Taylor Still Medallion of Honor from AAO Pres. Raymond J. Hruby.

The Academy wishes to extend its appreciation to Program Chairman, Boyd R. Buser, D.O., for a most informative program. We received numerous comments from attendees on the program content and in Dr. Buser's excellent choice of speakers. This year's registration showed 195 doctors and 200 students in attendance. All in all, it was a most successful Convocation.

The Academy also wishes to convey its special appreciation to Conclave Chairman, Robert C. Ward, D.O., F.A.A.O., for the excellent program presented on Saturday afternoon. It was entitled "Raised With Osteopathy: It's All in the Family."

The American Osteopathic Board of Special Proficiency in Osteopathic Ma-

nipulative Medicine met throughout Convocation to accomplish many items of business and interview applicants. Orals and practicals were given on Sunday, March 17th and Monday, March 18th. *The Fellows Dinner* on Thursday evening was attended by 55 physicians and guests.

The Structural Consultation & Treatment Service was offered once again under the excellent leadership of Ross E. Pope, D.O. A total of 248 treatments were given by 72 physicians during Convocation.

The General Membership Meeting was held on Wednesday afternoon immediately following the didactic sessions. The newly elected Trustees, Governors and members of the Nominating Committee are as follows:

President:
J. Scott Heatherington, D.O.

President-Elect:
Judith A. O'Connell, D.O.

Secretary-Treasurer:
John P. Goodridge, D.O., F.A.A.O.

Trustees:
William A. Kuchera, D.O., F.A.A.O.
William E. Wyatt, D.O.

Governors:
Myron C. Beal, D.O., F.A.A.O.
Alan R. Becker, D.O., F.A.A.O.
Boyd R. Buser, D.O.
Anthony G. Chila, D.O., F.A.A.O.
Lorane M. Dick, D.O.
John Glover, D.O.
Deborah M. Heath, D.O.
Robert E. Irvin, D.O.
Jillellen McKee, D.O.
Thomas L. Shaver, D.O.

Nominating Comm.:
Barbara J. Briner, D.O.
Anthony G. Chila, D.O., F.A.A.O.
Lorane M. Dick, D.O.
Jerry L. Dickey, D.O., F.A.A.O.
Michael L. Kuchera, D.O., F.A.A.O.

By a unanimous vote of the Academy members, Honorary Life Membership was bestowed upon Drs. Myron C. Beal, Naples , New York, a member since August 1954; Doran A. Farnum, San Juan Capistrano, California, a member since June 1949, and William L. Johnston, East Lansing, Michigan, a member since April 1951.

UAAO NEWS

UAAO Program

Program Chairman, George Pasquarello, put together an excellent program with some pretty outstanding speakers; Neal Cross, Ph.D. lectured on "OMT: It Is More Than Just Laying On Of Hands"; Ken Johnson, UNECOM Anatomy/OP&P Fellow, lectured on "The Integrated Approach to Osteopathic Treatment of Pregnant Women"; Frank Willard, Ph.D., lectured on "A Neurobiological Approach to Facilitated Segments," and Student Doctor Lizabeth Smith lectured on the research she has been doing at MSU-COM. (UAAO Council Chairman, Joe Ruane, also gave a presentation, but we were not given the title before this publication went to press.) Two of the lectures were given during the scheduled lunch break on Wednesday, March 20th and the remainder of the program on Friday afternoon, just prior to Laurie Jones' Marketing Workshop.

Business Meeting

The annual UAAO Business Meeting was held on Wednesday evening. We heard comments from AAO President, Raymond J. Hruby, D.O., F.A.A.O. and AOA President, Mitchell Kasovac, D.O. National Advisor, Michael L. Kuchera, D.O., F.A.A.O., brought everyone up to date on the Residency + 1 Program. John "Andy" Burgess, D.O., who originally came up with the idea of a National UAAO was given an award, and the outgoing council officers presented with plaques. Each of these people are to be commended on the outstanding job they did while in office.

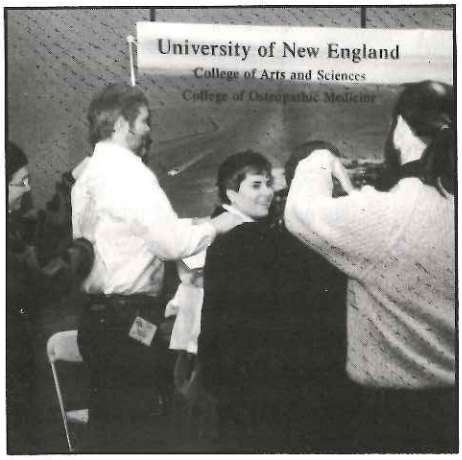
Elections were held and the newly elected officers are as follows:

Chairman:
George Pasquarello

Vice-Chairman:
Roberto Corales

Secretary:
MaryEllen Kistler

National Coordinator:
Gail MacIntyre



Students from UNECOM receive some "hands-on" training from John "Andy" Burgess, D.O.

Fun For All

All who participated in the pre-convention ski trip, the night out at "The Heat" in Colorado Springs and the ice skating at the World Arena had an enjoyable time.

Medical Alert

Allergic Reactions to Latex-Containing Medical Devices

Because of reports of severe allergic reaction to medical devices containing latex (natural rubber), FDA is advising health-care professionals to identify their latex-sensitive patients and be prepared to treat allergic reactions promptly. Patient reactions to latex have ranged from contact urticaria to systemic anaphylaxis. Latex is a component of many medical devices, including surgical and examination gloves, catheters, intubation tubes, anesthesia masks, and dental dams.

Reports to FDA of allergic reactions to latex-containing medical devices have increased lately. One brand of latex-cuffed enema tips was recently recalled after several patients died as a result of anaphylactoid reactions during barium enema procedures. More reports of latex sensitivity have also been found in the medical literature. Repeated exposure to latex both in medical devices and in other consumer products may be a part of the reason that the prevalence of latex sensitivity appears to be increasing. For example, it has been reported that 6% to 7% of surgical personnel and 18% to 40% of spina bifida patents are latex-sensitive.

Proteins in the latex itself appear to be the primary source of the allergic reactions. Although it is not now known how much protein is likely to cause severe reactions, FDA is working with manufacturers of latex-containing medical devices to make protein levels in their products as low as possible.

FDA's recommendations to health professionals in regard to this problem are:

- When taking general histories of all patients, include questions about latex sensitivity. For surgical and radiology patients, spina bifida patients, and health-care workers, this recommendation is especially important. Questions about itching, rash or wheezing after wearing latex gloves or inflating a toy balloon may be useful. Patients with positive histories should have their charts flagged.
- If latex sensitivity is suspected, consider using devices made with alternative materials, such as plastic. For example, a health professional could wear a non-latex glove over the latex glove if the patient is sensitive. If both the health professional and patient are sensitive, a latex middle glove could be used. (Latex gloves labeled "hypoallergenic" may not always prevent adverse reactions.)
- Whenever latex-containing medical devices are used, especially when the latex comes in contact with mucous membranes, be alert to the possibility of an allergic reaction.
- If an allergic reaction does occur and latex is suspected, advise the patient of a possible latex sensitivity and consider an immunologic evaluation.
- Advise patients to tell health professionals and emergency personnel about any known latex sensitivity before undergoing medical procedures. Consider advising patients with severe latex sensitivity to wear a medical identification bracelet.

FDA is asking health professionals to report incidents of adverse reactions to latex or other materials used in medical devices. (See the October 1990 *FDA Drug Bulletin*.) To report an incident, call the FDA Problem Reporting Program, operated through the U.S. Pharmacopia toll-free number: 800-638-6725. (In Maryland, call collect 301-881-0256.) For further information on the clinical aspects of latex sensitivity, call Claudia Gaffey, M.D., FDA Office of Health Affairs, Center for Devices and Radiological Health, at (301) 427-1060.

For a single copy of a reference list on latex sensitivity, write to: LATEX, FDA, HFZ-220, Rockville, MD 20857.

Albert F. Kelso, Ph.D. talking with John P. Goodridge, D.O., F.A.A.O. in the exhibit area.

Kathryn Calabria, DO, from Merrick, NY, who won one-half off her 1992 convocation registration fee in a drawing from those who completed their exhibitor visitation cards is congratulated by Frank C. Walton Sr, DO, and Ross Pope, DO

Items Of Interest

Army Major John H. Gillespie, D.O., of Fayetteville, North Carolina died February 17th in Saudi Arabia. He was the first physician know to have died in the Persian Gulf War. He died as a result of an accident that was non-combat related. Dr. Gillespie was a 1983 graduate of MSU-COM and served an Anesthesiology residency at Brooke Army Medical Cebter at Fort Sam Houston, Texas. He was stationed with the 121st Evac hospital group based in San Francisco. In 1990, he was sent to Fort Bragg to train medics. He was shipped to the Gulf in October and was assigned to the 28th Medical Hospital - part of the 18th Airborne Corps.

David L. Kushner is the new President and Chief executive Officer of the American Osteopathic Hospital Association effective January 1, 1991. He is replacing Richard Strano.

From the *Hawkette Osteopathic Journal*

More than 1 in 3 medical students in America are women - The actual percentage is 36.1, up from 25.4 in just 10 years. Average debt for all medical students is $42,000.

Please Note Our New Address

The Academy was recently notified by the US Post Office that our new zip code would be changing. Anytime our P.O. Box 750 is used in a return address, the zip code MUST read, 43058-0750. Please make a note of this in your records. Thank you.

1991 Convention

Title of the 96th AOA Annual Convention and Scientific Seminar is "Osteopathic Medicine: Defining the Future."

Bureau of Research program: The Future of Osteopathic Medicine Is In Research. The conference will conclude with a half-day forum which will focus on the development of working professional relationships between D.O. and Ph.D. researchers.

Mitchell Kasovac, D.O. discusses program with James lipton, D.O.

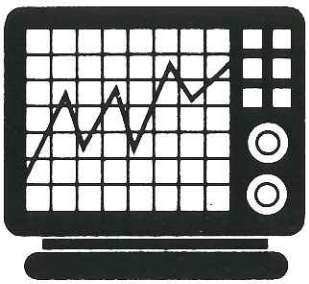
CALENDAR

May 31-June 2, 1991 - Washington
1991 IFH Professional Case Conference
Please write or call for more information. IFH Professional Case Conference, 2366 Eastlake Ave East, Suite 301, Seattle, WA 98102-3331; (206) 3245-8230.

June 7-11, 1991 - Texas
The Sutherland Cranial Teaching Foundation is sponsoring a 40-hour basic/intermediate course titles "Osteopathy in the Cranial Field in the Practice of Dentistry", to be held at the Texas College of Osteopathic Medicine. Course Director: John H. Harakal, D.O. 40 hours CME. For more information contact Judy Staser, Executive Secretary, at 4204 Bilglade Road, Fort Worth TX 76109; (817) 735-2498.

June 14, 1991 - California
Clinical Review sponsored by Osteopathic Physicians & Surgeons of California; held at College of Osteopathic Medicine of the Pacific, Pomona, CA. 11 CME credits anticipated. Contact Linda Wahlen at the OPSC central office, (916) 447-2004.

June 18-19, 1991 - California
The Health Sciences Communications Association (HeSCA) is holding a 2-day seminar, titled *Television in Health Care*, at the Annenberg Center for Health Sciences in Rancho Mirage, California. This meeting will take an in-depth look at video's unique place in health care communications. For more information contact: HeSCA 6105 Lindell Boulevard, St. Louis, MO 63112, (314) 725-4722



June 27-30, 1991 - Colorado
Annual Meeting by Colorado Society of Osteopathic Medicine. Educational topics on pediatric respiratory emergencies, post traumatic stress syndrome, cancer update for GPs, diabetes and peripheral vascular disease, common foot emergencies. Featuring hike, family picnic, mountain bike ride, golf and tennis. 18 hours category 1-A CME credits; 18 hours AAFP prescribed course credits. Copper Mountain Resort, Copper Mountain, Colorado. For more information contact Patricia Morales or Rowena Sedar at (303) 322-1752.

June 27-30, 1991 - Wisconsin
1991 Illinois Association of Osteopathic Physicians and Surgeons Annual Convention.
Location: The Abbey Resort on Lake Geneva, Fontana, WI

July 22-26, 1991 - Oklahoma
The Sutherland Cranial Teaching Foundation is sponsoring a Basic Course "Osteopathy in the Cranial Field", to be held in Tulsa OK. 40 hours 1-A CME credit expected. Tuition $800. For more information contact Judy Staser, Executive Secretary, at 4204 Bilglade Road, Fort Worth TX 76109; (817) 735-2498.

September 6-10, 1991 - Michigan
Introduction to Esoteric Healing. The program is sponsored by The International Health Research Network. It is the first in a four-part series that teach principles and techniques of Esoteric healing. Course location is Park Inns International Hotel in East Lansing. A block of rooms is reserved at a discount rate. Call (517) 351-5500 for reservations. For more information call Dr. Barbara Briner (517) 349-7377 after 7:00 pm.

September 13-15, 1991 - California
Osteopathic Physicians & Surgeons of California 2nd Annual Mid-Year Seminar, "Dr. UR Your Bottom Line," Sheraton Santa Barbara Hotel & Spa. Stuart B. Chesky, D.O., and Norman E. Vinn, D.O., co-chairs. 18.5 hrs CME. Take time to focus on the business side of practice. Contact Matt Weyuker, Executive Director, at (916) 447-2004.

September 27-29, 1991 - Toronto
The Worker in the Workplace: Rehabilitating Musculoskeletal Injuries. Hands-on satellite workshops pre- and post-symposium. Contact Marc White, Executive Director, Physical Medicine Research Foundation, 510-207 West Hastings St., Vancouver, B.C. V6B 1H7. Phone (604) 684-4148, Fax (604) 684-6247.

October 3-6, 1991
OMT Update and Review
Walt Disney World,
Orlando, Florida.
This Academy program is designed for the physician desiring the following:

- OMT Review — "hands on experiences and troubleshooting"
- integration of OMT in treatment
- preparation for AOBSPOMM certifying boards
- good review with relaxation and family time

October 5, 1991 - California
Clinical Review sponsored by Osteopathic Physicians & Surgeons of California; held at College of Osteopathic Medicine of the Pacific, Pomona, CA. 11 CME credits anticipated. Contact Linda Wahlen at the OPSC central office, (916) 447-2004.

October 12-14, 1991 - Texas
The Sutherland Cranial Teaching Foundation is sponsoring a Continued Studies Course at UNECOM. Course

Director: James Jealous, D.O., F.A.A.O Tuition is $350. Contact Judy Staser at 4204 Bilglade Road, Fort Worth TX 76109; (817) 735-2498. A new publication, The Teachings in the Science of Osteopathy, based on the lectures and teaching of William Sutherland, D.O., edited by Anne Wales, D.O., with forward by Rollin Becker, D.O. and offered by the SCTF is available at $40 or $100 for the special limited edition plus postage. Contact Judy Staser for details.

February 12-16, 1992 - California Osteopathic Physicians & Surgeons of California 31st Annual Convention, "Celebrating 100 Years of Osteopathic Education," Biltmore Hotel, Los Angeles, CA. Joseph A. Zammuto, D.O., Convention Chair. 35 hrs Cat 1-A CME anticipated. Contact Matt Weyuker, Executive Director, at (916) 447-2004.

June 5-7, 1992 - Washington 1992 IFH Professional Case Conference
Please write or call for more information. IFH Professional Case Conference, 2366 Eastlake Ave East, Suite 301, Seattle, WA 98102-3331; (206) 3245-8230.

Classified

OMT Specialist Opportunity - Portland Oregon
Opportunity for OMT specialist available now at Eastmoreland Hospital in scenic Portland, Oregon. Eastmoreland Hospital is a 100-bed acute care teaching hospital with a 20-bed exempt rehabilitation unit. Excellent compensation and benefits. Board certified, or eligible preferred. Send CV to Ken Giles, Administrator, Eastmoreland Hospital, 2900 S.E. Steele St., Portland, Oregon 97202; (503) 234-0411

Exciting Practice Opportunity- Well established, thriving OMT practice seeking DO skilled in cranial, functional, muscle energy, fascial release and high velocity techniques. Diverse patient population in excellent midwest community of Dayton, Ohio. Regular hours in beautiful new office facility. For more information call: (513) 461-4151, Judith A. O'Connell, D.O.

New Procedures for the Visiting Clinician and Visiting Scholar Programs

Through the diligent efforts of the AAO College Assistance Committee, new guidelines and procedures have been established for the Visiting Clinician and Visiting Scholar Programs. Participants in the Visiting Clinician are D.O.s and Scholars are Ph.D.s.

To participate in the programs, all interested parties must complete an application form and submit it with a photograph and a current curriculum vitae. These will go to the College Assistance Committee for their review and recommendations will be forwarded to the Board of Trustees for their action. It is our intention to take the photographs and the information from the application form and put together a booklet with the clinician's or scholar's picture and a brief description of their area of expertise.

Applications and report forms were mailed to all the current Visiting Clinicians and Scholars and the response has been tremendous. These programs allow the schools to bring lecturers directly on campus for interaction and hands-on sessions with both students and faculty members. They have been very successful in the past and we want this trend to continue.

If any of our members are interested in applying for either of the programs or if you know someone you feel would be a definite asset to either program, please contact: College Assistance Committee, American Academy of Osteopathy, P.O. Box 750, Newark, OH 43058-0750.

At this time, we asking that all inquiries be in writing rather than requesting the information by telephone.

A.T. Still & Nutrition
Continued from page 5.

References

1) Young, V.R.: Metabolic and nutritional aspects of physical exercise. Federation Proc. 1985:44;341-342
2) Truhlar, R.E.: A.T. Still in the Living. Ohio. Robert E. Truhlar. 1939. pp. 13-149
3) Physiology of aerobics. New Scientist. 1984:101;15-17.
4) Stamford, B.: The results of aerobic exercise. Physician and Sports Med. 1983-11;145.
5) Forbes, G.B.: Body composition as affected by physical and nutrition. Federation Proc. 1985:44;343-347.
6) Nieman, D.C. Vegetarian dietary practices and endurance performance. Am. J. Clin. Nutr. 1988:48;754-761.
7) Wood, P.D.; R.B. Terry and W.L. Haskell: Metabolism of substances: diet, lipoprotein metabolism and exercise. Federation Proc. 1985:44;358-363.
8) Henson, L.C.; D.C. Poole; C.D. Donahoe and D. Hober: Effects of exercise training on resting energy expenditure during caloric restriction. Am. J. Clin. Nutr. 1987:46;893-899.
9) Riemenschneider, P.A. and J. W. Shields: Human central lymph propulsion. J.A.M.A. 236:18;2066-2067.
10) Shields, J.W.: Central lymph propulsion. Lymphology. 1980;13:9-17.
11) Costill, D.L.; Carbohydrate nutrition before, during and after exercise. Federation Proc. 1985:44;364-368.
12) Gollnick, P.D.: Metabolism of substrates: energy substrate metabolism during exercise and as modified by training. Federation Proc. 1985:44;353-357.
13) Manore, M.M.; J.E. Leklem and M.C. Walter: Vitamin B-6 metabolism as affected by exercise in trained and untrained women fed diets differing in carbohydrates and vitamin B-6 content. Am. J. Clin. Nutr. 1987:46;995-1004.
14) Pi-Sunyer, F.X. and R. Woo: Effects of exercise on food intake in human subjects. Am. J. Clin. Nutr. 1985:42;983-990.
15) Dohm, G.L.; G.J. Kasperek; E.B. Tapscott and H.A. Barakat: Protein metabolism during endurance exercise. Federation Proc. 1985:44;348-352.
16) Stamford, B. When to eat and exercise. Physician and Sports Med. 1988:16;184.
17) Stamford, B. What time should you exercise. Physician And Sports Med. 1986:11;162.
18) Twaigery, S. and D.M. Spillman: An introduction to moslem dietary laws. Food Tech. 1989:43;88-90.

Don't miss this one!

American Academy of Osteopathy

OMT UPDATE

"Application of Osteopathic Concepts in Clinical Medicine"

and

"Preparation for OMM Boards"

October 3-6, 1991

Walt Disney World
Orlando, Florida

This Academy program was designed for the physician desiring the following:

- OMT review — "hands on experiences and troubleshooting"
- integration of OMT in treatment of various cases
- preparation for OM practical portions of certifying boards
- preparation for AOBSPOMM (American Osteopathic Board on Special Proficiency in Osteopathic Manipulative Medicine) certifying boards
- good review with relaxation and family time

DATES:
Thursday PM — Sunday AM, October 3-6, 1991

PLACE:
Walt Disney World, Orlando, FL
WDW Resort Club Villas and Conference Center

CME HOURS

	AAO	Non-AAO
3.5 days — 19 hrs-1A	$395	$435
COST (D.O.)		
or		
.5 day — 5 hrs-1A	$ 95	$105

COST FOR RESIDENTS/INTERNS
$100 — LIMIT of 20
(based upon 80 full pay D.O.s)

FACULTY:

Ann L. Habenicht, D.O.
— certified — GENERAL PRACTICE
— certified — AOBSPOMM
program chairperson and table trainer

Speakers/Table Trainers
Richard Dobrusin, D.O.
— certified — AOBSPOMM

John G. Hohner, D.O.
— certified — GENERAL PRACTICE
— board eligible — AOBSPOMM

Judith O'Connell, D.O.
— certified — AOBSPOMM

Melicien Tettambel, D.O.
— certified — AOBSPOMM
— certified — AOBOGS

Frank C. Walton, Sr., D.O.
— certified — AOBSPOMM
— certified — GENERAL PRACTICE

Table Trainers
Boyd Buser, D.O.
— certified — AOBSPOMM

Daniel T. Davison, D.O.
— certified — GENERAL PRACTICE

Christine Janouschek, D.O.
— certified — GENERAL PRACTICE

Kenneth E. Nelson, D.O.
— certified — AOBSPOMM
— certified — GENERAL PRACTICE
— certified — FAMILY PRACTICE — AAFP

Schedule

THU. PM

4:30	Opening Reception
4:30- 4:45	Overview of the Course Applications of Osteopathic Concepts in Clinical Medicine — What to Use: When and Why
4:45- 5:25	High Velocity, Low Amplitude; (HVLA) — includes question and answer period
5:25- 6:05	Muscle Energy — (as above)
6:05- 6:45	Counterstrain — (as above)
6:45- 7:25	Myofacial Release — (as above)
7:25- 7:45	Cranial-Sacral — (as above)
7:45- 8:30	Summary — "Putting it All Together"

FRI. AM

7:00- 7:45	Breakfast Buffet
7:45- 8:30	Lecture — Cervical/Suboccipital Troubleshooting (to include various modalities approach — HVLA, ME, counterstrain, indirect-MFR & cranial)

Continued from page 23

8:30-10:00	Skills Session — Cervical/Suboccipital (based on AOBGP practical cases)
10:00-10:15	Break
10:15-11:00	Lecture — Thoracic Troubleshooting
11:00-12:30	Skill Session — Thoracic
12:30- 1:00	Wrap Session (Summary)
FRI PM	Free time for Exploration

SAT AM

7:00- 7:45	Breakfast Buffet
7:45- 8:30	Lecture-Lumbar/Pelvis Troubleshooting
8:30-10:00	Skills Session — Lumbar/Pelvis
10:00-10:15	Break
10:15-11:00	Lecture — Appendicular Troubleshooting
11:00-12:30	Skills Session — Appendicular
12:30- 1:00	Wrap — Summary

SAT PM	Free Time or Underground Disney Tour — 4 HR tour for Disney resort guests only (anyone registered with program). Cost is $55 additional. Minimum of 15 people. Must be paid with registration. *Highly recommended by those who have taken this tour in the past. Additional Prep for Boards — may be taken as .5 day only

SUN AM

7:00- 8:00	Breakfast Buffet
8:00- 9:00	Case Study Prep — how to write them
9:00-10:00	Written Exam Prep — what to expect
10:00-10:15	Break
10:15- 1:00	Oral Prep — "What to expect & how to do it!" (individual troubleshooting available)

ADJOURN

American Academy of Osteopathy

Conference Registration Form

OMT UPDATE

Oct. 3-6, 1991 Walt Disney World, Orlando, FL

Fee:	AAO member	Non-AAO
3.5 days — 19 hrs 1A	$395	$435
or		
.5 day — 5 hrs 1A	$ 95	$105

Cost for residents/interns $100 — limit of 20 (based upon 80 full pay D.O.s)

Name _____

Address _____

City _____ State _____ Zip _____

( ) _____

Telephone

Make check payable to:

American Academy of Osteopathy
P.O. Box 750
Newark, OH 43058-0750
(614) 366-7911

RETURN ADDRESS:
AMERICAN ACADEMY OF OSTEOPATHY
1127 MT. VERNON RD.
P.O. BOX 750
NEWARK, OH 43055

NON-PROFIT ORG.
U.S. POSTAGE
PAID
PERMIT NO. 267
NEWARK, OH