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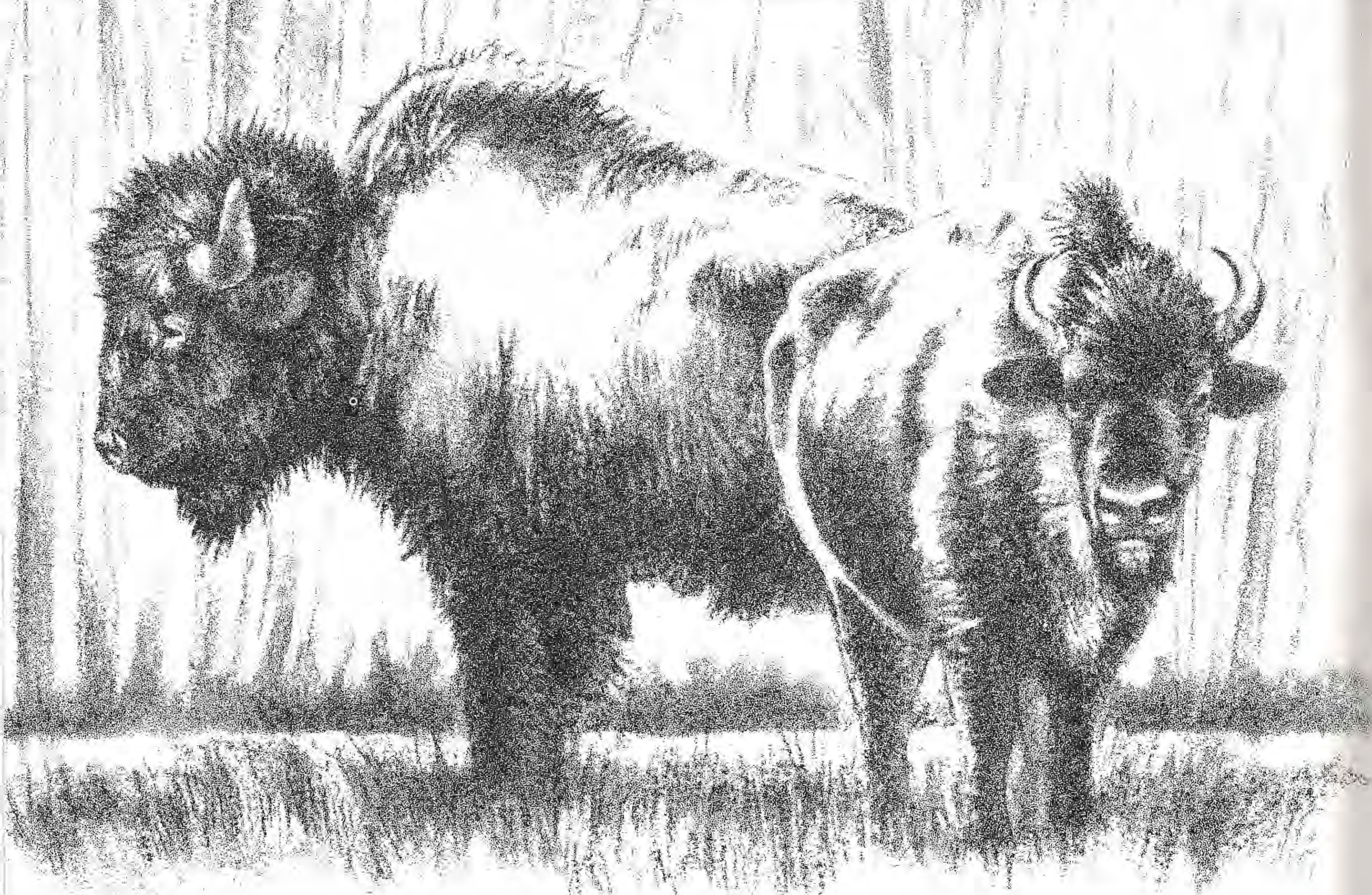

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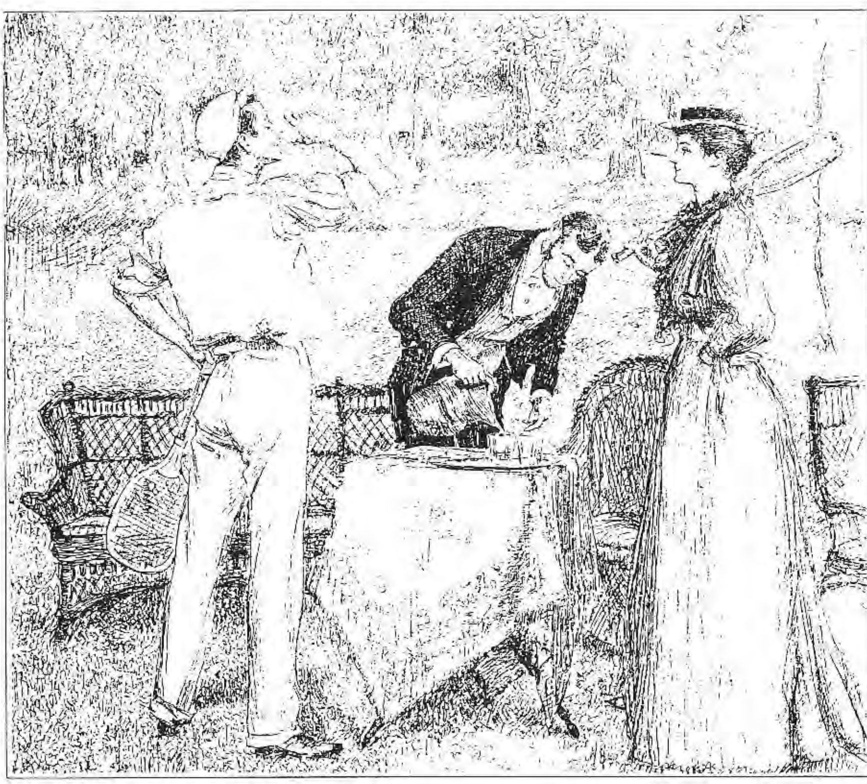
From the Editor

SUMMER IS HERE... WELL, MAYBE



T. S. Eliot is one of my favorite poets, and has been ever since I first began to explore his work when I was in high school. In one of his most famous works, "The Waste Land", there are some lines that I find to be most significant right now:

> April is the cruellest month, breeding
> Lilacs out of the dead land, mixing
> Memory and desire, stirring
> Dull roots with spring rain.

Well, April is a very cruel month for us here in New England this year. As I sit here at my computer, writing this on Easter weekend I can look out the windows of my den and see the foot of snow that just yesterday surrounded my house and filled my woods. At this time of the year we expect better weather than this even in New England, and I for one expected to be out playing baseball today. (Yes, I know some people think baseball is boring, but what do they know?!).

But my approach to life is to look for the best in everything, and in spite of my desire for Summer to arrive, the snow in the woods and on the pine boughs and birch limbs is beautiful, and I like to use the peaceful silence this kind of snowstorm brings to study, to think about all kinds of things. As usual, I've been studying some of A. T. Still's writings, and something he said in The Philosophy and Mechanical Principles of Osteopathy (p. 17) led me to some interesting thoughts. He said: "We must remember that when we write or talk, we have asked the reader or listener to stop all pursuits to read our story or listen to it. We must be kind enough to give him something in exchange for his precious time." I wondered: if Doctor Still, who liked to be precise and to the point, were living in this age of 15 second "sound bites," what definition of a D.O. would he give to the public? Without looking any further at his writings I decided to challenge myself on this, and this is what I came up with: "A D.O. is a fully licensed physician whose goal is to treat the patient in the context of that patient's total life and health care status. This is done by optimizing the patient's own self-healing mechanisms and maximizing his/her body's structural and functional relationships, utilizing osteopathic manipulative treatment as well as standard medical and surgical methods when necessary."

This definition may not be perfect but I find it helpful when explaining Osteopathy to others. If you haven't ever done this, I would challenge you to do so. If somebody stuck a video camera in your face RIGHT NOW what definition of a D.O. could you give in 15 seconds or less? Imagine yourself in this situation and see what you can create. If you come up with something you like and want to share it, send it in and we'll publish it here in the Journal. In the meantime, I hope your April weather was a little less cruel than mine. See you at the ball park!

Raymond J. Hruby, D.O., FAAO

AAO President's Inaugural Address

March 1992

by Judith A. O'Connell, D.O.

As I stand before you, I am humbled. The task that lays before us is formidable. The changes that need to be made are great. Yet, I am filled with hope and excitement! You are the creators of a new medical system and I am proud to have been chosen by you as President in this great new time of opportunity!

I have been evaluating myself and reviewing the steps that preceded me here. I have searched my soul for direction and guidance so that I may lead in concert with Divine Destiny. I have a great urgency of purpose that is fueled by a vision of a system of health that respects the individual and the dynamic total. It acknowledges the Divine in all creation. It deals with all creation with respect, responsibility and love. It transcends all levels of disease manifest in individuals, societies, the world community and the universe, both human and non -human. It is one based on order and harmony in tune with Divine Guidance.

As I reflect back on my life, I realize that this vision has been with me since I was seven years old. And before the vision became concrete, I always acted and felt a great respect and love for all of creation and for the benevolent God that we are a part of. Of course, medicine had to be my chosen profession so that my vision could come to pass. I have always known that I had to be a leader in my vision, not out of ego, but out of a deep knowing that this was true. I accepted that and I trusted that this too would come to pass.

In college, I was introduced to Osteopathic Medicine through the direction of one of the most spiritual people that I have had the honor of knowing, **Dr. Peter Faso**. He was my pre-med advisor. He recognized me and my vision and had directed me to **Mary Theodoras, D.O.**, who in turn opened my awareness to Osteopathic Medicine. To my jubilation, I found out that A.T. Still had the same vision! I knew that this was my path. I knew that the spirit of Osteopathy was truth and that the medicine of the future would come from here.

In the years since then, I have grown and opened my awareness to conventional medicine and have been dissatisfied. I looked at my colleagues and saw no soul. I feared that the vision was lost. I searched for a place to plant the seed again and the most fertile ground I found was here, in the AAO. The Academy has preserved the vision, but the light of the vision was dim. I began to cultivate the rich soul (soil) and I found more people who shared my vision, who had been led to Osteopathy as an alternative, and who resonated with the vision. I became involved.

I stand before you now, ready to engage the future, ready to place Osteopathic Medicine in its rightful place as the basis for the medicine of the future. I need your help. Become active in the Academy on committees. Voice your opinions to me and the rest of the Board of Trustees, Governors and the Executive Director. I cannot do this alone. We must do this together. ❑

Letter to the Editor

Regarding an article in the Spring, 1992 Journal about alternatives in schools of manual medicine practicing in the United States, it should be pointed out that manual medicine is a term used to distinguish manual procedures performed by physicians. Therapists do not prescribe medicine, nor do massage workers or body workers. It is a mistake, I feel, to group into one category all forms of massage, body work and physician applied procedures. This makes it appear that we are doing nothing more than massage. In fact, osteopathy applies specific diagnostic procedures with a specific pathologic assessment that then requires a specific manipulative prescription over the course of time to remedy. Schools of body work and massage therapy do not offer a medical degree, have no such system of diagnostic and therapeutic prescriptions, and therefore should not, in my opinion, be considered schools of (manual) medicine.

It is extremely important in this day and age that we as the osteopathic profession, along with our brethren M.D.s who practice manual medicine, define and protect the body of knowledge and scope of practice considered manual medicine. As physicians, we have to maintain standards of practice as well as education to insure the quality and safety of our work and our profession. There are many interests in the health care market today having no standards of practice or education. I think it is in our best interest to distinguish ourselves from these other disciplines, especially in our own journal!

Sincerely,
Harry D. Friedman, D.O.

Message from the Executive Director

I am certainly fortunate to have had the opportunity to "hit the ground running" when I began my duties on April 1 as the Academy's Executive / Education Director. From January 13 through March 31, I served as a consultant while I fulfilled the remaining days of my contract with the Indiana Association of Osteopathic Physicians and Surgeons. During that period, I was fortunate to spend at least one day each week at the Academy's executive offices in Newark, Ohio learning the job from outgoing Executive Director Dick Dyson and the rest of the dedicated AAO staff. I also was able to attend two key committee meetings —Education and Long Range Planning. The last week in March I had the pleasure of attending the 1992 AAO Convention in Kansas City, where I was present for meetings of the Board of Trustees, the Board of Governors, and six committees. I am sure you can appreciate the depth of understanding that these experiences have brought me.

Perhaps the most exciting thing that I have observed to date is the high level of enthusiastic activity on the part of the Academy's leaders and members to fulfill the Academy's mission, which was approved in March by the Board of Governors:

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

I fully expect that you all will continue to support the Academy at the same level in the future with your time, talents and material resources. In fact, I encourage those who are not involved currently to become actively involved in the future as AAO committee members, treating physicians for the Academy's structural consultation/treatment service, registrants at one of the educational meetings of the Academy or component societies, or in some other volunteer capacity.

The Academy is on "the cutting edge" in representing its members on the matter of coding for osteopathic manipulative medicine (OMM) under Medicare's Resource Based Relative Value Scale (RBRVS). **Dr. Richard Feely** is chairman of the AAO's Ad Hoc Committee on Federal Regulation on OMM and is directing the committee's efforts in communicating with Medicare and with the AOA leadership on upgrading the work values for OMM using the MO-codes. The Academy also has secured two key nominations to committees established by the Health Care Financing Administration (HCFA) to update the RBRVS in the future. HCFA appointed **Dr. Herbert Yates** as one of two osteopathic representatives on the Relative Value Update Advisory Committee. The AOA also nominated **Dr. Judith O'Connell** to serve on HCFA committee which will review and evaluate comments received by HCFA on the work values assigned to RBRVS codes.

I am thrilled to be able to serve the Academy as its Executive Director! Don't hesitate to write or call if you have questions or comments. I welcome the opportunity to meet you!

Sincerely,

Stephen J. Noone, CAE

ACADEMY LEADERSHIP TAKES ROLE IN REPRESENTING OSTEOPATHIC PROFESSION FOR OMT CODING

by Stephen J. Noone, Executive Director

The Health Care Financing Administration (HCFA) appointed AAO President **Judith O'Connell** to a special committee which reviewed the comments on "work values" for RBRVS codes. The committee met on May 18 at HCFA headquarters in Baltimore. Despite the fact that the American Osteopathic Association had supported the relative values assigned by HCFA to the Osteopathic codes (MO702ff), **Dr. O'Connell** and AAO member **English, D.O.** were able to convince HCFA representatives that the "work values" for these MO-codes should be increased from those published earlier and currently being used for reimbursement by the Medicare program. What happens next? HCFA representatives agreed to advocate the recommendation for increase at the next level — let's hope the change will be implemented! Dr. O'Connell reported favorable feedback from HCFA staffers who appreciated the advanced preparation on the part of the delegation and the clarity in presentation of OMT for the committee.

HCFA also has established a 26 member RVS Updating Committee (RUC) which is charged with reviewing the "interim" values assigned to CPT codes in Medicare's Relative Value Scale. **Ray Stowers, D.O.** has been appointed to this committee representing the osteopathic profession. The RUC also has the luxury of an Advisory Committee which represents the various specialties in

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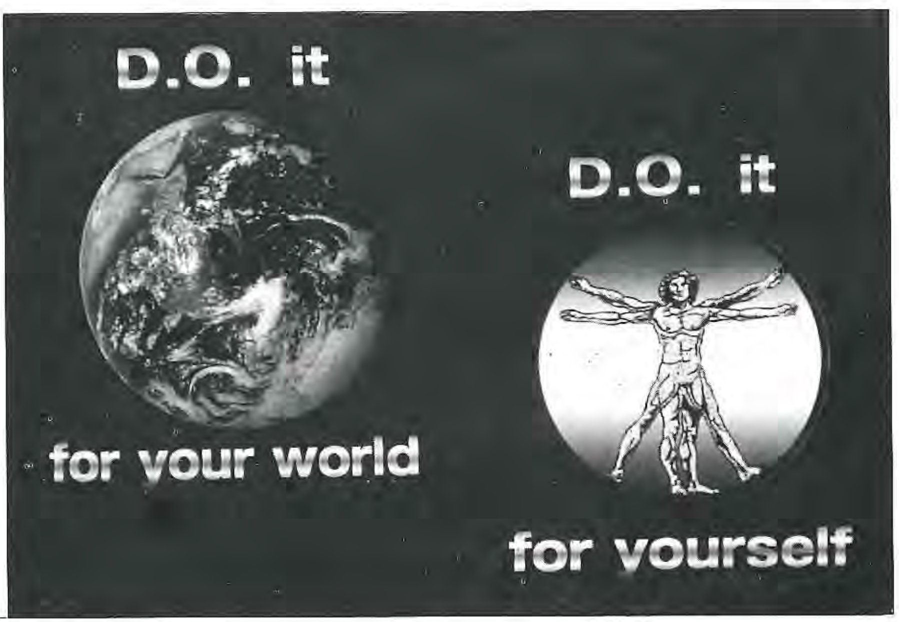
Osteopathic Green: Applying the Philosophy of A.T. Still

by Michael L. Kuchera, D.O., F.A.A.O.

1992 marks the celebration of 100 years of osteopathic education and in recognition of this centenary, the UAAO has planned a national environmental educational campaign centered around the application of the osteopathic philosophy. You are all encouraged to participate in the project which will culminate in a national "media event" documenting our educational and environmental efforts on Earth Day, 1992. Properly conducted, we will greatly extend public recognition of the relevance of our communities and the world.



The Project

Each chapter, its individual members and their colleagues are asked to teach the application of the osteopathic approach in promoting "world health." Our "patient" is the planet earth. By extending the osteopathic tenets to cover ecological/environmental concerns we hope to spread the osteopathic philosophy to audiences not previously reached. According to recent surveys, the vast majority of Americans are environmentally concerned. As you read the rest of this article, take note that your charge is two-fold:

1. Educate others about the osteopathic philosophy as it applies to environmental health; and;

2. Be good role models for the application of the tenets you have chosen to guide your therapeutic choices.

Applying the Osteopathic Philosophy

According to the final tenet of our philosophy, rational osteopathic health care decisions are based on applying the following three other osteopathic tenets. For this project we will emphasize how to apply these tenets in making rational choices in the health care of the planet "earth":

1. Like our bodies our planet has self-healing, self-regulating mechanisms which allow for elimination of wastes while resources are appropriately allocated where the need is greatest. Local overprotection of wastes and/or shortages of resources are compensated for until the homeostatic mechanisms of the planet are overwhelmed. The osteopathic approach teaches us to enhance those homeostatic mechanisms that are functional and to remove impediments to those that are dysfunctional.

2. Like our bodies, our planet is a unit. Each of us as individuals plays a role in the health of our planet, each serving an important function. While individually our actions and recycling accomplishments may seem inconsequential, acting as a community with common goals allows each individual to contribute to the health of the whole. Thus health of the larger unity depends upon health of the smallest sub-unit. On a global scale, the osteopathic approach teaches each of us the importance of our individual actions and our role as an integral part of our families, our communities, our organization, and our nation.

3. Structure and function are interrelated within our bodies, within our social structures, and globally. Just as the design of this environmental education program was carefully

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Case Study

A Patient With Bilateral Shoulder Pain

Submitted by Boyd R. Buser, D.O.

*Starting with this issue of the AAO Journal, we will present a case study taken from the case studies submitted by those who have been certified of AOBSPOMM. This issue's case study is submitted by **Boyd R. Buser, D.O.**, Chairman of the Department of OP&P at the University of New England College of Osteopathic Medicine in Biddeford, Maine.*

The cervicothoracic spinal transitional area can effect upper extremity function in several ways. This case demonstrates the effect of distortion of this area on the upper extremities from a biomechanical-neuromusculoskeletal as well as respiratory circulatory point of view.

Report of Case

A 54-year old white female presented to the clinic with a chief complaint of bilateral shoulder pain. She stated that the onset of these symptoms was gradual, beginning approximately ten months previously, after a fall on her boat. She stated that immediately after this fall she began to experience some tightness in the left upper thoracic region which extended into the left posterior shoulder region. As time progressed, she began to gradually experience pain in the superior and anterior portions of the left shoulder joint. This pain had also gradually developed in the same area of the right shoulder. The symptoms had been steadily worsening. She had taken aspirin for the pain, with minimal relief. Her job was clerical in nature and she had missed no work secondary to these complaints. She denied any past surgical history. Her past medical history was essentially noncontributory. She denied any medication allergies, and stated that the only medication she is presently taking was the aspirin.

Examination revealed the deep tendon reflexes to be intact and equal in the upper extremities bilaterally at +2/4. Muscle strength testing in the upper extremities was +5/5 in all areas. Range of motion of the glenohumeral joints was full bilaterally with reproduction of the anterior shoulder pain with the arms overhead and internally rotated. Standing examination revealed no evidence of significant lateral spinal curvatures. Supine exam revealed a slight increase in the lumbar lordotic curve. The lumbar spine was found to be sidebent toward the left with compensatory right rotation. The lower thorax was slightly deviated toward the left. T1 was found to be rather significantly rotated and sidebent toward the right. There was a resultant deviation of the upper portion of the sternum toward the right. T3 was found to be rotated and sidebent toward the right and accompanied by acute tissue texture changes in the paravertebral muscles. Assessment of this patient included:

1. Supraspinatus tendonitis bilaterally.

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Somatic Dysfunction: A Neurophysiologic & Osteopathic Overview

by Antonios J. Tsompanidis

Over eighty million Americans suffer from some form of chronic pain.[6] One of these forms manifests itself as back pain. Sufferers seek to alleviate back pain through the use of physical therapy, drug therapy, surgery, manipulation, or a combination of therapies. Before a physician can prescribe any such treatment, it would be beneficial to understand the neurophysiological aspects of back pain. Specifically, an osteopathic physician should understand the relationship between pain, the nervous system, and the effects of OMT (osteopathic manipulative therapy).[1]

When an osteopathic physician is presented with a patient who has an ailment associated with a musculoskeletal disorder and accompanying pain, the D.O. ascribes the diagnostic term somatic dysfunction (once known as an osteopathic lesion) to this condition. The term somatic dysfunction is a term ascribed to represent what is now known to be a very complex phenomenon. It is this concept of somatic dysfunction that distinguishes osteopathic medicine from other medical professions. Thus, a clear understanding of all the aspects of a somatic dysfunction is integral to effective treatment via OMT.[4,7]

A somatic dysfunction is defined as an impaired or altered function of related components of the somatic (body framework) system: skeletal, arthroidal and myofascial structures, and related vascular, lymphatic, and neural elements.[1] From this definition, it is evident that there are many interrelated components to a somatic dysfunction. Somatic dysfunctions have several origins. They can originate in musculoskeletal restriction. They can be triggered by trauma or disease in the central nervous system as well as by persistent autonomic impulses due to structural and functional changes. These changes may also be infectious in origin. Overall, there are many explanations and theories which deal with the initiation of a somatic dysfunction.[7] The neural mechanisms and the changes effected on them will be further discussed.

In December of 1947, **Dr. I.M. Korr** published in the JAOA an article entitled "The Neural Basis of the Osteopathic Lesion." From that time, Dr. Korr has developed a widely accepted neural model dealing with both the origin and maintenance of somatic dysfunction.[3,7] Dr. Korr explains that since the musculoskeletal system is the largest somatic system, it receives a majority of the efferent outflow from the central nervous system (CNS). Conversely, the musculoskeletal system is also the source of much of the sensory input to the CNS. This sensory reporting also plays a role in the adjustment of motor control. Therefore, disturbances in the sensory input from the musculoskeletal system can impair motor function as well as the autonomic nervous system's tuning of body function in response to sensory input. This premise is the somatic dysfunction's foundation.[3]

Dr. Korr's theories indicated that the musculoskeletal restrictions of a somatic dysfunction were usually accompanied by increased excitability in the motor neurons serving the affected muscles. Thus, hyperirritable neurons chronically shorten muscles producing motion restriction.[7] It was further postulated that hyperexcitable motor neurons were the result of afferent input to the spinal cord from some proprioceptor, namely muscle spindles. Muscle spindles were chosen since they are sensitive to musculoskeletal stresses.[3,7] Therefore, effective OMT would have to cause a reduction in the afferent stimulation thereby reducing the motor neuron's hyperexcitable state. In effect, various osteopathic techniques "reset" the muscle spindles which allows for muscular relaxation.[3,4] As Dr. Korr stated, "one of the most reliable hypotheses is that the entire nervous system from the highest centers of the brain to the peripheral neurons is involved in all somatic dysfunction and in every manipulative treatment".[4]

Recently, there seems to be a new hypothesis which builds on Dr. Korr's foundation. The problem resides with Dr. Korr's choice of muscle spindles. It has been shown that other receptors can elicit the same type of responses that lead to somatic dysfunctions. For example, visceral tissues, which have no muscle spindles, can trigger responses. Furthermore, muscle spindle afferents are not usually sufficient enough to activate motor neurons and can also act in an inhibitory manner toward motor efferents.[7] Thus, the new choice for a receptor must be capable of performing all of the aforementioned factors and more.

The alternative receptor choice is the nociceptor or pain receptor. Since pain almost universally accompanies somatic dysfunction, the nociceptor

seems to be a logical alternative choice. Nociceptors are peripheral neurons which originate as nerve endings in the connective tissue of the body and are consequently found almost everywhere. Upon stimulation, nociceptors produce an action potential that is directed at the CNS as well as at the periphery. The peripheral action involves the release of peptide neurotransmitters which actively participate as vasodilators as well as mediators of inflammatory and immune responses. The CNS is involved since the nociceptors have connections in the brainstem and the spinal cord. The result are two reflexes which involve the musculoskeletal system and the autonomic nervous system respectively.[7]

Somatic dysfunction can now be considered as much more than a typical musculoskeletal disorder. Pain, autonomic stimulation, immune response and other events are causally related to somatic dysfunction. Nociceptors are common to all of these events "by including musculoskeletal restriction and autonomic, visceral, and immunologic deficits as consequences of [their] mechanism of action" and thus "appear to explain satisfactorily all the major features of somatic dysfunction".[7]

With all of this information relating pain, somatic dysfunction, and neurophysiology, the question of OMT's use and efficacy to alleviate dysfunction arises. Although there are many techniques, all of them prove effective. For example, with muscle energy, the muscles are stretched to their maximum point or the barrier. Upon voluntary contraction of the affected muscles by the patient, the respective motor neurons are activated and block the nociceptive pathway. The muscles can now be further stretched through the barrier. Counterstrain shortens muscles maximally which removes stresses and deactivates the nociceptors. Myofascial techniques also shorten the affected connective tissues and muscles. In the latter two techniques, the tissues are later slowly stretched to decrease the chance of reactivating the nociceptor. Finally, with high velocity/ low amplitude techniques, the affected tissue is carefully taken to its abnormal limit (no further nociceptor stimulation). An additional stretch is applied that is small and quick. This stretch reorganizes the affected tissues back to normal.[7] Therefore, the valid use and effectiveness of OMT is indicated. "Patients who undergo [OMT] often experience the relief of debilitating pain, and a renewed sense of ease and lightness of motion...".[4]

With this interrelationship of OMT and pain relief, why is it not widely accepted? After all, pain and specifically back pain are not uncommon and are economically costly. In England, it was reported that 375,000 people annually lost work time due to back pain and 46% of a national sample had been inconvenienced by back pain.[5] In America, 60% of all Social Security Disability Claims involve the allegation of pain and $11 billion is lost per year due to work disability. Therefore, the goal of health care should be effective treatments that are also cost effective.[6] However, it appears that society's view of pain relief is via drug therapy. This is clearly seen by watching a television commercial for pain medication. More recently, a commercial showed a doctor prescribing acetaminophen to a patient with back pain because "it will make us both feel better". Drugs such as these are cheaper than seeing a D.O. for OMT and thus people simply put up with their problems. However, more times than not, if the problem persists, these same people will resort to a D.O. for treatment. This occurs because the drugs taken only alleviate the symptom but do not correct the cause of the disorder. This is especially true if the problem involves the spine, muscles or joints. These mechanical disorders can be cured mechanically but not by drug therapy. At this point, it may be necessary for more treatment sessions and return visits, since the problem has persisted for a long time. If treated initially with OMT, there would be a decrease in the number of visits necessary to attain a therapeutic goal and economically it would have been more cost effective.[2]

The importance of the relationships of pain, neurophysiology, somatic dysfunction, and OMT to the osteopathic physician are explained. By understanding these factors, one can better perfect the osteopathic modality of healing to benefit society and the osteopathic profession. ❑

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Antonios J. Tsompanidis is a second year student (class of 1994), class president, UMDNJ-School of Osteopathic Medicine, Stratford, NJ.

RHEUMATOID ARTHRITIS: THE INCURABLE DISEASE?

by Harlan O.L. Wright, D.O.

Until December of 1989, Maria (not her real name) had apparently been in good health as judged by our present day American standards. She had been able to do all of her housework, take care of her children and do the normal physical activities required of the average thirty-eight year old female. In December of 1989, all of that suddenly changed. Marie awoke one morning with some distressing joint pains in various joints of the body, particularly the fingers, wrists, knees and ankles. She had difficulty walking after she got out of bed. She noticed that the involved joints were tender to the touch. Maria didn't become alarmed and started to take the usual over-the-counter analgesics for some measure of relief. As weeks went by, the pain became worse and the swelling became more noticeable and the joints were now becoming somewhat inflamed and warm to the touch. It was at this point that Maria decided to see a doctor. The doctor, after the usual medical investigation, diagnosed Rheumatoid Arthritis (R.A.) and prescribed a non-steroidal anti-inflammatory drug which she took for awhile but which didn't do anything except upset her stomach.

Over the course of the next few months she saw different doctors who prescribed various other pain medications and antiinflammatory drugs. She thought that the drugs were doing more harm than good and stopped taking all of them and at the advice of a friend sought other methods of therapy.

On June 28, 1990 I first saw Maria in my office. She was assisted into the office by her husband because her ankle and foot joints were so swollen and painful that she could not bear her full weight on them. Attempts at mobility and joint movement anywhere on her body were obviously causing her considerable pain.

She gave the following history: She had never before had an illness which she considered serious. In January and February she had a continuing sore throat for which she had been given different antibiotics. She said that the antibiotics didn't do much good and that the sore throat finally went away. During the interim between the bouts with her sore throats and the beginning of the joint pains in December, she began to experience repeated bouts with vaginal infections and discharge. She had always been constipated.

Maria's diet was that of the average American these days and considered "well balanced" by the average practitioner. It consisted of regular servings of meat, potatoes, tortillas, some vegetables and plenty of snacks of soda pop, candy, chips and ice cream.

Examination of this patient revealed a thin patient (she had lost about 30# since her R.A. started) with some acne manifestations of the facial skin. Tongue was noticeably coated. Heart and lungs were not remarkable. The joints of her fingers displayed the typical fusiform configuration of Rheumatoid Arthritis. Her wrists were moderately swollen. Her knees were moderately swollen as were the ankle joints. All of the involved joints were very tender as were the spinal joints. Movement of the involved joints was about 25% of normal and even that with severe pain. She could barely flex her fingers and could come nowhere near making a fist.

The obvious diagnosis was correct—Rheumatoid Arthritis but a less obvious and frequently overlooked diagnosis in many of these autoimmune problems was Chronic Systemic Candidiasis.

Treatment: In a case such as this it is imperative that the digestive system be restored to normal function as soon as possible and that the constipation be overcome so that the body

can detoxify itself. The patient was therefore started on lots of raw fruits, vegetables, nuts, whole grain cereals and breads for the fiber content and also Betaine HCl tablets to assist in her digestion.

Mycostatin Powder was prescribed for the candida infection in doses of 1/4 teaspoon twice daily in water. All sugar foods, soda pop and milk products were stopped completely. Intravenous drips consisting of large doses of the Vitamin B complex, amino acids, procaine, Magnesium, Calcium and 25,000 mg. of Ascorbic Acid in 500 c.c. of Ringers Lactate were given. Each drip given slowly, taking about one hour and thirty minutes. These drips were given twice a week for the first two weeks and then about once weekly for the next two months and then thereafter only occasionally as judgement indicated. Osteopathic manipulative treatment was also administered.

Daily oral supplement therapy was as follows: A potent Vitamin and Mineral tablet, Ascorbic Acid Powder 8000mg. in divided doses, Calcium 1000 mg., Magnesium 500 mg., Niacinamide 500 mg. after each meal, zinc gluconate 100 mg., Pyridoxine HCl 100 mg., Kelp 3 tablets, Cod Liver Oil one-half ounce and Soy bean "milk" as desired.

Clinical judgement indicated a measure of adrenal exhaustion and so she was given 5 mg. of prednisolone a day as a temporary measure until some of her severe and acute problems could be minimized. (This is considered to be approximately what the adrenal gland produces daily). She was also given one grain of thyroid daily since I have found that most patients with this type of problem feel much better with a little thyroid assistance.

Clinical Progress: As frequently happens in patients with Systemic Candida problems, Maria felt worse for the first two weeks of her treatment. This is apparently a "die off" effect as the body is cleansing itself. I had warned her of this possibility so she did not stop the treatment. However, when she returned for her check up on July 17, 1990 she was elated. The pain and stiffness had eased a lot and the swelling was diminishing. She was now able to walk carefully without assistance. She continued her progress slowly, having some bad days, (particularly when the weather was inclement) but many more good days than bad.

By Sept. 20, 1990, Maria was only taking 2 1/2 mg. of prednisolone. She was having no pain in the ankles and only very moderate occasional pain the knees and hands. She was able to do most of her housework and use her hands very well. I didn't see her again until May of 1991 at which time I saw her for another problem. She had continued to follow her dietary program and supplements. She was completely off all prednisolone and analgesics and was having no pain in her joints. The last time I saw this patient was on March 6, 1991 at which time she was still almost completely free of arthritis discomfort except on cold days when she has a little stiffness. She continues to do a normal days work and can completely clinch her fists. Much of the fusiform swelling of the joints has disappeared. By the way, her acne cleared up also.

Comments: I see so many chronic health problems that respond beautifully to natural methods of treatment, including Osteopathic Manipulation. It is a constant source of bewilderment to me why the medical profession generally, yes and even our own osteopathic profession specifically, resist and even ridicule these simple and common sense methods which usually have no side effects and can cause no harm, in favor of the use of so many powerful drugs that cost infinitely more money, have untold side effects and admittedly cause many of the drug induced problems that other doctors then try to cure with more drugs. The reason the osteopathic profession came into existence was for the purpose of trying to heal the patient without harm.

Is it possible that in our desire to demonstrate our equality we are denying the very special and different talents which have endeared us to such a large segment of the public who are searching for our unique difference? ❑

Harlan O.L. Wright D.O., is in private practice in Lubbock, Texas.

Catherine S. Becker Memorial Fund Established

Alan R. Becker, D.O., FAAO., a past president of the Academy, has donated $2600 to initiate the Catherine S. Becker Memorial Fund which is to receive the principal and residual income of a charitable remainder unitrust created by Dr. Becker. The current principal of the trust is estimated to be in excess of $200,000. Dr. Becker intends to donate the income from the trust to the Catherine S. Becker Memorial Fund.

Cay will be remembered as a strong supporter of the Academy. For many years she served as hostess, receptionist and secretary for the Academy's Structural Consultation and Treatment Service at AOA conventions and Academy convocations. Cay always had a cheery word for everyone and this commemoration will symbolize her kindness, generosity and love for the Academy. ❑

AAO WORLD REPORT

by Robert C. Clark, D.O.

This year, 1992, Osteopaths the world over celebrate the 100th anniversary of Osteopathy. As we look back and reflect upon the past century, we must remember that although Osteopathy is an American healing art, it's growth and success has been world wide. There are strongholds of Osteopathy in England, Australia and New Zealand. History repeats itself around the world. The Australians, for example, lost their school to the political actions of the chiropractors just as the Californians lost their school to the allopaths. Fortunately for Osteopathy both have built new schools to replace those once lost. Today as the world grows smaller through faster transportation and instant communication it is more important than ever for Osteopaths world wide to unite for the growth and promotion of the profession. After all we are the best physicians in the world; it is now time to make sure the world knows this fact!

To that end we begin our efforts with news around the Osteopathic World with correspondent **Jean-Pierre Noelmans, D.O.**, of Ledeberg (Gent), Belgium. He reports that in August of last year, he and four others formed The Sutherland Cranial Academy of Belgium. He tells us "One of the most important aims of this association is to promote activities in the field of Osteopathy such as seminars, workshops and other activities that make it possible for the members to rediscover or to deepen Osteopathy with the accent on Cranial Osteopathy." Dr. Noelmans closes, " We, here in Belgium, are aware of the necessity of keeping in touch with the native country of Osteopathy."

On the other side of the world, AAO member, **Louise Adam, D.O.**, writes, "I am heartened and excited to be part of the first national association of Osteopaths in Australia. It has made our efforts much more productive for the profession as a whole. The association, called the Australian Osteopathic Association, was formed by the merger of four state based organizations. It is in fact the continuation of the Australian Osteopathic Association that was first established in 1941 by graduates of Dr. A.T. Still." She reports that the new organization has representation on all registration (license) boards and works closely with the faculty of the Osteopathic Sciences Unit, Phillip Institute of Victoria, which is the only osteopathic school in Australia. As of the fir st of this year there are 200 members. The first president of the Australian Osteopathic Association is Dr. Adam and the secretary is **Mansur Fraval, D.O.**

Since its formation in October of last year the new organization has been very active. Projects under way include uniform standards for registration or licensure, as we in the U.S. call it, from state to state which would allow reciprocity of licensure; establish reciprocal registration between Australia and the United Kingdom (England); and establish registration in the state of Western Australia.

The osteopathic profession in Australia gained significant status with the passage of legislation allowing patients to go directly to Osteopaths for treatment of work related injuries without first having to be referred by a M.D. under the nation's worker's compensation program. Australian D.O.'s responded eagerly to the first Sutherland Cranial Teaching Foundation introductory course in Australia. U.S. **Drs. Edna Lay** and **John Harakal** lead the five day program. The class sold out and will be repeated later this year in Sidney.

Lastly Dr. Adam included a copy of the first issue of the Australian Journal of Osteopathy published by the Australian Osteopathic Association. This excellent journal will be of interest to the Osteopaths of any country. It contains a wealth of clinically oriented osteopathic articles. Articles include "Status of the Osteopathic Knowledge Base and Research" by **Albert Kelso, Ph.D.**, "Thinking Osteopathically in the early 1900's" by **Philip Latey, D.O.**, a cranial case study by Dr. Fraval, and two articles on the sacrum and one on the coccyx by other authors. The Australian Journal of Osteopathy contains osteopathic history, diagnosis and treatment and new ideas to stimulate the reader. There are two editions published each year. To subscribe contact **Brigitte Muller, D.O.**, 15 Russell St, Cardiff, NSW 2285, Australia. Rates in Australian Dollars are $56 for surface mail or $68 for airmail.

Our overseas colleagues are fighting many of the struggles in gaining recognition that we in the U.S. encountered many years ago. It is in our best interest to support them as we all work to promote the value and benefits of Osteopathy. Our experience will make their efforts easier. Until next time. ❑

WILL YOUR RECIPE EVEN BE IN THE COOKBOOK?

by Lynne Ammann-Hasbrouck, Ed.D.

More than one hundred years ago, A.T. Still settled in Missouri after he was run out of Kansas for his heretical ideas. Where will YOU go if osteopathy is run out of the U.S.A.?

Medicine rapidly is becoming more and more regulated and standardized. With the increasing intervention of government in the purchase and regulation of health care, we have seen a corresponding increase in attempts by most provider and payer groups to influence governmental decision-making. The goal of most of the provider groups is to buy protection for their particular methods of doing things and for practitioners of the same. The goal of most of the payer groups is to buy the power to force health practitioners to provide their services for the lowest possible price.

The American Medical Association, the American Hospital Association, other health practitioner organizations, pharmaceutical companies, insurance companies and consumer groups have expensive and highly effective lobbies that keep their issues, wants and needs in front of local, state and national legislators. Two of the ways they do this are by financially supporting the political campaigns of sympathetic legislators, and by organizing massive write-in and phone-in campaigns by the general public.

The immense and expensive bureaucratic infrastructure created by the government to oversee and undertake the day-to-day payment/regulatory activities also has a vested interest in having its wants and needs met. The bureaucracy wants to keep its job, expand its scope of activity, and magnify its importance. Therefore, it has to be able to be somewhat effective. In order to be effective, it has to have an understanding of those services which it is regulating/paying for. This requires codifying and standardizing diagnosis and treatment so that the newest, lowest-level clerk can easily recognize:

1. The diagnosis at which you arrived,

2. The treatment you rendered,

3. Whether or not the treatment rendered is acceptable according to a predetermined (usually allopathic) protocol,

4. The amount of time you spent rendering treatment, and

5. The least amount of money the government (and soon, the insurance companies) can get away with paying for said treatment.

To assist the bureaucracy in accomplishing this task, allopathic medicine has been busy developing "cookbooks" for various specialties. Each cookbook sets forth the accepted standards and methods of diagnosis and treatment for the various maladies and conditions generally considered to be the (jealously guarded) province of that particular specialty.

Osteopathy's contribution to this incredible undertaking and to its consequences for the profession has been equally substantial. Year after year, under the guise of educating eager and committed young women and

men to become true osteopaths, many osteopathic schools, by design or by accident, have turned out thousands of M.D. clones who just happen to have the initials D.O. after their names.

These doctors are the product of primarily allopathic course work, graduate from mostly allopathic residencies, prepare in allopathic ways to practice allopathically-defined specialties, take and support the requiring of allopathic-designed proficiency tests, accept allopathic principles and open up TOTALLY allopathic practices. This is fine if the profession does not care and has been planning its own demise. However, if you became an osteopath because you actually embrace the osteopathic philosophy, principles and practices, you soon could be in REALLY big trouble.

The pharmaceutical and insurance industries support the allopathic medical model because 1) it supports the use of drugs as cures, 2) its methods of treatment are more easily observed, quantified, learned and coded for acceptability and payment, and 3) there are more medical practitioners who financially and vocally support this model.

The forces that oppose osteopathy have long recognized the power of politics to create and shape that which is permitted to exist and thrive. They have been so successful in using this power to shape public policy and attitudes about health care that many people don't have the vaguest idea what a true osteopath is or does. In recent years, the response of the osteopathic profession largely has been to accept the dictates of allopathic medicine and the government to fit in. Osteopathy barely has managed to obtain codes in the diagnostic and treatment manuals for its procedures and methods of treatment. This, plus maximum reimbursement for same, seems to be the primary focus of activity on the part of osteopaths who manipulate. Such an approach is akin to trying to contain a forest fire with a fence.

The harsh reality is that once allopathic cookbooks for treating any particular condition have been created and accepted, osteopathic treatment for the same condition may become (first) unpayable, (then) litigious and (finally) illegal.

What can you do? You can begin to:

1. Accept the reality that **you must become aware of what is going on in local, state and federal legislation that affects you and osteopathy;**

2. **Make your views known to legislators at all three levels. Write articulate letters. Circulate petitions. Make phone calls;**

3. **Educate your patients about what is happening, and encourage and assist them to contact their legislators on this issue.**

a. Create a notebook with relevant articles to put in your waiting room. Encourage patients to read them, and provide copies upon request.

b. Create sample letters for patients to send to their legislators concerning current or pending legislation or rules that will affect your practice and osteopathy. (The average American reads and writes at the sixth-grade level, so you will need to provide something patients can copy or simply personalize with a brief note and sign.)

c. Post signs encouraging patients to tell a friend about the developments in managed health care and what it means for all patients and all doctors.

d. Educate your patients about what osteopathy is and about what you do. Make the history and practice of osteopathy the focus of your office decor. (KCOM's Still Museum can help you with materials for this.)

e. Be proud of who you are and what you represent and **Show it!** Use the osteopathic logo on your stationery, wear osteopathic T-shirts and buttons, put up signs **'Osteopathy spoken here.' Celebrate** the 100th year of osteopathy!

f. **Remember that most legislators base their decisions on votes or campaign contributions. Your patients' votes are some of your most valuable assets. Use them!**

More than one hundred years ago, A.T. Still settled in Missouri after being run out of Kansas for his heretical ideas. Where will **YOU** go if osteopathy is run out of the U.S.A.? ❑

Lynn Ammann-Hasbrouck, Ed.D. and her husband, Louis Hasbrouck, D.O., are practicing in Montana.

The Final Four

KCOM - OTM

Student Fellows

are seeking skulls, bones, and Osteopathic books with which to embark on our careers as Osteopaths. Willing to enter into extended payment arrangements if necessary. Please contact Tom Byrnes, David Harden, Rob Gitlin, or Karla Frey-Gitlin c/o OMM Department 800 W. Jefferson St., Kirksville, MO 63501, (816)626-2304/2107. Thanks.

Is Osteopathic Education Ready For Its Next Century?

by Scott R. Corbett, Student Physician,
College of Osteopathic Medicine of the Pacific

Osteopathic medicine is entering its second century at a time when the practice of medicine is in transition unprecedented in the past 40 years. Changes which have touched almost every aspect of medicine in the past decade are more indicative of a shift in the paradigm that shapes medical practice than a series of isolated events. Medical education in this country not only has not kept up with the changes, it may be losing its role in setting the agenda for health care delivery. Medical colleges must change their programs to reflect the new demands being placed on physicians as well as to deliver more effective health care to our patients. The cost of not doing so may mean losing peoples' faith in the medical profession's dedication to the improvement of their health. The Colleges of Osteopathic Medicine have an opportunity to implement new programs in their curricula that will make future D.O.'s more capable and versatile physicians.

Osteopathic medicine offers a distinctly different approach to medical care than that found in other disciplines; however, it seems many of the differences remain in the realm of the theoretical and historical without necessarily being translated into practice. While comparing ourselves to M.D.'S may have been necessary since the time of the Flexner Report to establish competence and professional validity , it has also meant taking on the limitations inherent in their system of disease management. Using only acute observation of the body and an intuitive sense of its function, A.T. Still formulated many prophetic principles which are only now beginning to be validated with research. Now might be a perfect time to reexamine his original precepts to see if they bear revitalizing and re-emphasizing.

The traditional relationship among the patient, doctor, disease, and cure can be termed reactive, or mechanistic. In such a system, a disease, sickness, or injury has a rapid onset, requires fairly rapid treatment, and will yield to treatment or leave the formerly healthy patient compromised in some way. The physician reacts to the condition being presented, which is already well underway. Such conditions are usually traumatic to the patient or his family. Typhoid fever, smallpox, and hip fractures are examples of this class of conditions. The cause of the disease or injury may be viral, bacterial, chemical poison, or physical harm; the distinguishing characteristic is the random and external causative agent. The patient was simply the victim of being in the wrong place at the wrong time. Treatment of such conditions requires decisive action by medical

personnel armed with the latest information on diagnostic and treatment procedures. Medical miracles have become more and more commonplace as formerly fatal conditions yield to a new synthetic antitoxin or surgical procedure.

As long as the pace of discoveries and research continued to accelerate, hope abounded for a cure for every disease just around the corner. Technology, it seemed, would find a resolution for every medical malady in due course. Doctors and medical researchers were regarded in the highest esteem, and deservedly so. However, after many of the more troublesome diseases had been drastically reduced or completely eradicated, the diseases that were left in their stead seem to be unwilling to yield to the same methods of attack. The cure for cancer that has been promised since the 1960's and now costs many, many billions of dollars per year simply is not materializing. Not only do we have different diseases to deal with, but we need an entirely different approach to their treatment. The traditional method of crisis intervention, so effective in its proper place, should no longer dominate medicine. Today patients are rightfully questioning why the world's most expensive health care is not giving them better lives. While some of the shortfall may be attributed to legislative and insurance factors, some of the blame goes to physicians and health care administrators for focusing on short-sighted goals and not on long-term wellness for their patients.

The diseases that today rank as America's most lethal are relatively new, considering medical history. Fevers, plagues, and stones are mentioned in accounts back to the beginning of recorded history. Colon cancer and atherosclerosis did not receive much coverage in historical writings. Heart disease and cancer alone account for over 1,000,000 deaths per year in the US. The interesting, and astounding, fact is that most cancer and almost all heart disease is considered to be preventable through simple, known, dietary and lifestyle measures! Despite the fact that this is widely acknowledged, little activity can be seen on the part of the government or health care establishment. In fact, the recent FDA nutrition campaign designed to replace the antiquated basic four food groups with a simple scheme reflecting current knowledge was cancelled at the start of printing due to pressure from the dairy and meat industries whose products were deemphasized in the new plan.

This new group of diseases only responds to a completely new approach to their treatment; traditional surgery and pharmaceuticals do not provide a complete, long lasting solution in these cases. A proactive approach is required. By the time a patient presents with acute atherosclerosis it is too late to have any effective modification of lifestyle to prevent its occurrence and we must resort to reactive, invasive measures which leave the patient in a state of compromised well-being.

In the proactive, or holistic approach to wellness, certain characteristics inherent in the process must be considered to be of any use. Of immediate concern is the causative agent. Unlike reactive conditions, the patient is responsible for everything he or she chooses to call a lifestyle, be it diet, career, or choosing to smoke. This makes discussion of the condition a sensitive issue. Secondly, the onset is very long and cannot be attributed to any one isolated action. The cause of the condition may be at once simple to identify and embarrassing to acknowledge. Similarly, the cure may be easy to prescribe, yet difficult to implement. As such it is hard to come up with standard treatments, and since attitude is such a part of the condition, each case is unique. The physician has no magic bullets to compare to antibiotics for these diseases. That profoundly alters the physician-patient relationship. Partnership is required in an unprecedented way. The patient must be empowered to be his own physician, with the D.O. as an adviser and coach, not a savior. Since treatment may last thirty to fifty years, motivating patients to comply is critical.

In treating a condition in a reactive manner, it is fairly clear what the desired outcome should be. The Hippocratic oath has been our guide as we seek to do everything possible to eradicate the disease. Patient, doctor, and family all agreed: a good outcome is a fairly black and white issue. The bad outcome was handled by the family and the patient, should he survive, in the best way they could. If the outcome were truly a function of negligence on the physician's part, the legal system determined how to handle restitution.

The situation has lately become much less clear because there is no longer a consensus as to what constitutes a beneficial result of treatment. Some of the time we have been trying to extend longevity without considering quality of life, lack of pain, consciousness, mobility, or mental competence. Not every patient, family member, doctor, or legislator agrees on which factor should dominate. We no longer have a suitable scale with which to measure success in medical endeavors, and it is breeding dissent. The notion that lack of disease is a worthwhile outcome is no longer appropriate to the times. Advances in knowledge and changes in prevalent diseases dictate that we invent a new register of success for medical treatment. I suggest we consider the relative presence or absence of well-being as the new measure of medical efficacy.

Well-being is far more than the absence of disease, and it is more than health. It takes into account many factors about the overall quality of life as experienced by the patient such as physical fitness and health, mental health and satisfaction, career fulfillment, harmonious family and marital relationships. It involves the subjective sum of the quality of all the interactions between the patient and his or her internal and external environments. How he or she is perceived in the community, or treated by his or her manager at work will all combine to create well-being or its lack.

Now that we have achieved much of medicine's promise of a longer life for more people, many of the present or future recipients are questioning the advance of average longevity without any substantial increase in quality of that extra life. The right to die movement and living wills' popularity is a signal that people are now interested in well-being and true health as opposed to simple absence of disease.

The truth of the matter - and we profess to know this as osteopaths - is that caring, love, and attention probably do more to help a patient become well and contribute to their sense of well-being than some of the standard treatments rendered. That people are beginning to talk more loudly about their dissatisfaction with being treated callously and abruptly by physicians who don't listen should motivate us to enhance our curriculum to promote healing and wellness in our patients, selves, and colleagues.

Some allopathic schools are adopting osteopathic-like philosophies in response to public criticism of their methods. They are creating courses to train students in bedside manner, a few have courses in manipulation and touch, and some have students involved in clinical work from the beginning of their studies. It is time for us to raise the standard again and develop a philosophy that will carry us for the next one hundred years. If the public divines that we have knowledge that is not being used for their benefit because of resistance to change or lack of economic rewards, their judgment will be harsh. If we lead the way the rewards on both sides will be great.

Background Information:

• The health care environment has broadened significantly in the past ten years in terms of what is available for the average patient. It is no longer a simple matter of providing something slightly different from allopathic medicine to stand apart. We now have chiropractors, acupuncturists, hypnotists, dietitians, physical fitness trainers, and others offering health counseling advice . It is not uncommon for people to get their primary care from a chiropractor and only turn to a physician for more serious medical maladies.

• Preventive lifestyle change recommendations are taken most seriously and are most effective when given from personal experience. A doctor who recommends an exercise program coupled with dietary changes who doesn't follow his or her own advice is not likely to be heeded. Therefore, curriculum changes will have to involve the students in a way that they can have a personal experience of creating their own well-being, perhaps in lifestyle laboratory exercises.

• In a study of women with ovarian cancer one group was treated and sent to peer-group counseling to discuss the loneliness and isolation that having the disease brought them while another group of women (normalized for age, prognosis and so forth) was only given standard treatment. The patients receiving counseling lived over twice as long on average (37 months vs. 18 months). Would it not be considered neglect of duty if we didn't strongly recommend an effective counseling program for every patient with a terminal disease? Dr. Dean Ornish has shown also that heart disease patients showed dramatic improvements in recuperation when participating in similar sessions. Depression and bereavement have recently been shown to cause immune compromise and should be treated as part of an overall wellness plan for patients. We need to learn how to apply some of this research in a practical way as a part of our curricula.

• Given the statistics on cancer and heart disease deaths and given that our leading diseases are lifestyle correlated, a tremendously greater impact on the health of the nation could be made by altering this than spending a large sum of money solving another genetic metabolic problem that only a few hundred people in the country suffer from. They are both important, but more real benefits could accrue to the patients by implementing preventive programs that reflect objective information as early as possible in their education until such knowledge is known and accepted.

• Other cultures' health habits can show us ways to better health. In China, for instance, consumption of animal fat and protein is very low and the incidence of heart disease is much lower than ours. Their serum cholesterol is, on average, 125 mg/dl, which is about 90 mg/dl below our average levels. When Asian people adopt a Western diet, their heart disease and serum cholesterol increase to levels comparable to ours.

• Given that in lifestyle diseases exacerbating behavior is within the control of the patient more than anyone else, it is critical to develop a partnership in a way that does not condemn or alienate them. Since the

"treatment" may be a lifelong endeavor, patient compliance in the traditional sense would be very low. There are ways of stimulating patients to take responsibility for the outcome of their health care; we should be teaching them where appropriate.

Specific Curriculum Suggestions:

• Reorient our core and systems to approach topics from a wellness perspective. The beginning of the core curriculum and each system should remind us that wellness is our ultimate goal. Each of the system courses should be accompanied by information about how to prevent diseases in that system and how to design a program with a patient that would promote optimum system vitality.

• Develop a separate course that examines wellness and covers the following topics:

- Definition of well-being, including small group discussions
- Factors that promote health and wellness
- Preventive treatments regimens and how to apply them successfully. Some of our D.O. clinicians have a wealth of experience in the area.
- Patient motivation.
- Effects of attitude on health.
- Designing a wellness program for life.
- Effects of various environmental factors on wellness (noise, pets, pollution,etc.)
- Effects of exercise on attitude, motivation, health.
- Psychology of wellness versus psychology of disease.
- Alternative treatment modalities and where they fit into a balanced treatment plan.
- Death, dying and near death experiences
- Psychoneuroimmunology and neurocardiology

• Make college environments support the objectives of the curricula. Physical facilities, schedules, meal options, support services and other factors create an environment which either calls for well-being, allows well-being, or thwarts well-being. Similarly, a psychological and emotional environment is created by the attitudes of faculty and administration toward students, as does the qualities the various students bring to their class contribute to the environment. In both cases we should look to see that as much as possible the students make it through the schooling with self esteem, enthusiasm, health and vitality intact. The humanistic part of osteopathic philosophy applies to students and faculty. It is time we examined ourselves to make sure we are practicing what we preach.

• Give students direct experience with stress reduction, meditation, counseling, dietary changes, and so on. Use things that have direct clinical bearing, such as how to fast or use an elimination diet to detect food allergies.

• Require each student to do some community service on an ongoing basis in the medical field. People who do altruistic work are generally happier and more fulfilled than those that don't. Have this work begin early in the first semester. It may be a local patient that is assigned to the student for the two years, but in any case, it will help keep more clearly focused on why we are going through the effort to become physicians and enhance the course material's relevance.

• Actively pursue research topics that validate osteopathic tenets. Some evidence has recently been found that touch stimulates T-cell production and enhances overall immune system strength. We should be leading the way in this type of research, not resisting it. There are many concepts that need to be validated.

• Since most of the things discussed here are almost entirely issues of patient education, courses in how to get patients to follow lifestyle change recommendations would be essential.

The osteopathic philosophy has been well received by the public for over 100 years. It is sound, logical and helps people recover from some illnesses that other physicians are not able to treat. In areas which had to be accepted on faith in the past, recent research has begun to reveal the explanation that has eluded us. The sentiments of the general public are strongly in favor of what we have to offer and they like being treated with dignity, as whole people. The political and legal climate is moving toward favoring care that yields results and satisfied customers. Thanks to much hard work by many persistent D.O.'s, we now enjoy parity with M.D.'S and are accepted in virtually every health care arena. Everything seems to portend a bright future for us if we continue to grow and evolve. In Still's words, "We carry a flag of progress and should honor it with greater results by better applications of the principles of osteopathy. We must avoid the dust of habit" The only thing that could stop us from realizing our potential is ourselves. Now is the time to take simple, yet bold, action to create the future of health care or we may soon be watching it pass us by. ❑

Scott R. Corbett is currently attending The College of Osteopathic Medicine of the Pacific.

HELP WANTED

Opportunity available for Cranial Osteopath to join an established growing OMT-only. Practice in Maryland suburb North of Washington DC. Call (301) 587-7072 weekdays or (301 585-7023 evenings and weekends.

OBSERVATIONS

by Elizabeth C. Sanders

"I went to the woods because I wished to live deliberately, to front only the essential facts of life, and see if I could not learn what it had to teach, and not, when I came to die, discover that I had not lived."

Walden, written by Henry David Thoreau, was published in 1854. This classic and critically acclaimed piece of American literature is a beautifully written journal of a man's search for the truth and meaning in simple living. His is an ode to praise to living in harmony with nature and one's conscience.

Besides being a staunch abolitionist, Thoreau is the most profound champion of the American wilderness. The sanctity of the forest, the stream, the clean air and the fresh rain filled his life with glory and his fountain pen with fire. How interesting that Thoreau lived during the same period in American history as Andrew Taylor Still. The similarities between the men are quite amazing. Both men spent tremendous time and energy personally fighting the existence and propagation of slavery. They listened to the higher consciousness. These so called Immutable Laws of Nature emphasized harmony between man and the earthly world. Thoreau spent two Spartan years in the wilderness. Similarly, Still spent his entire life in frontier regions quite unfriendly and uninhabited. Even when he lived in Kirksville, which was quite a boom town in the late 1800's, he frequently spent his nights walking in the fields. Their returns to nature are more than symbolic. We have much to learn from these men.

We must recommune with Nature. Peace must be made between our existence and the environment. This earth is not ours to consume. If we continue with our recklessness and wanton life-styles, we will destroy the very energy of life. The meek shall not inherit the Earth because the greedy and selfish shall ruin it.

The words of Still live in the medicine we practice. The philosophy of Osteopathy continues with each pair of hands that are laid upon a patient in the name of healing. If we lay the hands of our hearts onto the flesh of this earth, she will heal. Like any patient suffering with illness and distemperment, unconditional love and nurturing can be the best medicine. ❑

LETTER TO A. T. STILL

Dear Doctor Still,

One of the more frustrating things we experience as osteopathic physicians is the difficulty we sometimes encounter in trying to explain to others the unique aspects of Osteopathy. I think for most of us this is something that we feel very deeply, and experience on a daily level while treating our patients, but we often find it difficult to put these profound feelings into words.

I often wonder what it would be like to be able to talk directly to you or to some of the people who studied with you about these things. It would be most interesting to hear how they described the uniqueness of osteopathic medicine.

Some people feel it is our use of osteopathic manipulation itself that sets us apart from other health practitioners. For instance, just the other day I read with great interest what one of your students, **Dr. M. A. Lane**, had to say about all this. He seems to feel that the uniqueness of Osteopathy lies in the use of manipulation and in the emphasis on immunity, that is, the ability of the osteopathic physician to directly affect the body's self-healing mechanisms through the use of hands on treatment. In his book, A. T. Still. Founder of Osteopathy, (pp. 165-166) he says: "...while drug-school physicians have been experimenting in the hope of finding cures for all infectious diseases by the avenue of serum therapy — that is, by introducing into the human blood stream the serum of lower animals that has been first infected with and then immunized to these diseases — thereby going about the solution of the problem in a wholly artificial way, osteopathic investigators have approached the task from a totally different angle — in fact, from the very opposite direction, by commanding, utilizing, directing and reinforcing the recuperative resources of the body itself, and this through perfectly natural and harmless means." So he really felt strongly that optimizing the self-healing mechanisms of the body was one of the cornerstones of Osteopathy. As for manipulative treatment, he had this to say: "By their system of manipulative therapy the osteopaths treat the human body itself. Instead of dealing with lower animals first, they treat the patient immediately and solely...they make all needed tissue adjustments and harmonize all the operations of the human organism so that without let or hindrance it may be able to prepare its own natural defensive substances as needed; and, then, further, by their art of stimulating the body's cells through work upon the nervous system...they enable the body in a practical way to manufacture its own antibodies, or contra-poisons, or antidotes which rout the disease germs, thus causing recovery from the disease."

Dr. Lane's ideas would certainly seem to be in agreement with your principles. It's interesting that our modern science is discovering the connections between the nervous, endocrine and immune systems, and the fact that we can indeed use manipulative methods to enhance the activities of these systems. Perhaps if we all continue to read your writings and those of your students who took the time to record what you taught them, we will understand all of this more thoroughly and be able to express more clearly what it is that we feel inside ourselves.

Your ongoing student,

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

From the Archives

TRY THE BEST FIRST

Reprinted from 1977 AAO Yearbook

Scott Memorial Lecture, 1977

Louise W. Astell, D.O.

With this issue of the AAO Journal we begin a new feature entitled "From the Archives." Here we will reprint a previously published item of clinical, historical or philosophical significance to osteopathic medicine. Many AAO members have expressed an interest in seeing more of our "classical" literature in print again.

The Scott Memorial Lecture was established by **Jeanette Scott Webster** and her husband, **Lawrence B. Webster**, as a memorial to Mrs. Webster's parents, **Katherine McLeod Scott, D.O.**, and **John Herbert Bryce Scott, D.O.**, for the purpose of honoring Andrew Taylor Still, the founder of osteopathy, and of reviewing his concept and skills. The lecture is given annually as part of the annual Founder's Day activities at Kirksville College of Osteopathic Medicine. The fund to support the memorial is administered by the American Academy of Osteopathy which, in cooperation with KCOM, selects the annual lecturer.

The story behind the Scotts' decision to study osteopathy is interesting and bears telling even for those who have heard it before. Mrs. Scott, a passenger on a steamship which collided with an ocean-going clipper, was thrown into the water, rescued, and confined to a wheelchair for three years with a back injury. Learning of Dr. Still's work, she went to Kirksville and, after receiving osteopathic treatment, was walking within six months. She went from a wheelchair to normal health and an active life. She and her husband were so impressed with this new concept in patient care that they enrolled in the American School of Osteopathy. He graduated in 1905 and she in 1906, and they practiced in Columbus, Ohio, for 50 years. Was Mrs. Scott's recovery a miracle? Perhaps; but Dr. Still's reasoning about a miracle was: "It may look to some like a miracle but it was not. It was simply a correction of a physical interference with the motor nerves that controlled movements."

While reading and rereading the literature both by and about Dr. Still, I felt that, had it been necessary, I would have become a born-again osteopath because it is so excitingly convincing. I recognize and accept the more sophisticated term "osteopathic physician," but today, as we honor Still, it seems appropriate to use his own designation, "osteopath."

Throughout the years, Still has been interpreted, misinterpreted, and reinterpreted, which is not unusual for anyone who ruffles the waters. Henry David Thoreau, approximately contemporary with Still, said, "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured and far away." This Dr. Still did when he became disenchanted with orthodox medicine as he witnessed and practiced it, and then founded the profession in which all of us are involved in one way or another.

There are as many definitions of osteopathy as there are people who have attempted to put their thoughts into words, and, indeed, Still defined his new knowledge in various ways. He often referred to the body as a machine and to himself as an osteopathic machinist who should "go no farther than to adjust abnormal conditions back to normal. Nature will do the rest." He saw the body as a whole and recognized its inherent capacity for health when nature had its way. Centuries earlier Hippocrates had expressed essentially the same principles, but it remained for Still to apply them to a philosophy of medicine for both health and disease.

"Osteopathy," he said, "is the knowledge of the structure, relations, and functions of each part and tissue of the human body applied to the adjustment and correction of whatever may be interfering with their harmonious operation." This definition of his understanding of the interrelationship of structure and function became the cornerstone of the concept that Still called osteopathy. After heartbreaking attempts to interest Baker University at Baldwin, KS, in his theory, which he wanted included in the college curriculum, he established the first school of osteopathy in Kirksville. The purpose of this school was "to improve our present system of surgery, obstetrics, and treatment of diseases generally, and place the same on a more rational, scientific basis." Although he did not propose a drugless therapy, there is no question but that his emphasis in diagnosis and treatment was on the musculoskeletal system. The literature is filled with thousands of case histories illustrating this point, and there are still to be found a few people who were treated by the "old doctor," and who attest to his ability to cure without the use of drugs.

"Go no farther than to adjust abnormal conditions back to normal. Nature will do the rest."

Many aphorisms are attributed to Still by his biographers, and his own writings contain still others of interest: "The rule of the artery must be absolute, universal, and unobstructed, or disease will be the result." (Most of us know this one as "The rule of the artery is supreme.") "To know all of a bone in its entirety would close both ends of an eternity." "Disease in an abnormal body is as natural as is health when all parts are in place." "If your foot stepped on a cat's tail, you would hear the noise at the other end of the cat, wouldn't you?" These are catchy phrases which, if considered in depth, would characterize the basic tenets of the osteopathic concept.

Still was never awarded the D.O. degree. He did not earn it by studying a formal curriculum; he just thought up the whole idea—one of the few original thoughts of the nineteenth century.

In 1974 we celebrated the 100th anniversary of Dr. Still's original announcement of his philosophy of medicine to the medical world. The designation osteopathy has caused concern to some people within the profession. As a result, there have been many attempts to define it broadly, to explain it or explain it away, or to justify it. In its simplest and most literal definition, it means bone (osteo) suffering (-pathy from *pathos)*, and Still defined it just this way in his autobiography. From the time he started thinking these new thoughts, he studied bones, thousands of them, in great depth. He knew the size, shape, and position of bones in the human body, together with the ligaments, muscles, and tendons attached to them, and their blood and nerve supply. A more specific statement than the aphorism on bones already cited is, "We must be sure that every bone is lined up and in its proper position, not held to the right or left by any muscular contraction which would follow irritation to the muscle or its nerves." He did not realize nor did he intend that "bone suffering" would give a narrow connotation to what he then considered and now is a complete system of health care.

In the years since osteopathy was announced, the meaning of the word has been researched periodically. An interesting defense of it was arrived at by **Ernest E. Tucker, D.O.**, and **Perrin T. Wilson, D.O.**: "Etymologically, the name osteopathy is correct, meaning the influence of the bones in relation with disease, causation and cure...Osteopathy then means osteo (bone), pathy (incoming effects from)."

I did a little searching, too, and found that one of the lesser known derivatives of the *suffix pathy* (from *pathos)* was "affection" which, in turn, was defined as "acting upon." Apparently it was from this derivation that the doctors formed their defense of the term *osteopathy*.

A few years ago, the designation *osteopathic medicine* was agreed upon, or at least accepted, by all official segments of the profession in order to have uniformity and to establish further its identity as a complete system in the healing arts. It has succeeded in this purpose to a large degree, but it has also confused the public. The word *medicine,* although used generically in our profession, still means drugs and an M.D. degree to the majority of people. Osteopathic medicine seems to many to be a paradoxical term and it has to be explained repeatedly; this becomes a part of our responsibility as osteopathic physicians.

What would Dr. Still think of all the discussion about the name he chose for the new profession and the principles he proposed? He was a plain man, close to nature, free of pretension, a hardy pioneer, and I suspect that he was impatient with the foibles of the sophisticated. He was also natively brilliant, creative, perceptive, and determined. If he were alive today, he would, I feel, undoubtedly approve of the profession's acceptance of progressive ideas in medicine when wise and necessary while holding on to the principles that have proved to be effective for over a hundred years.

We sometimes find ourselves

straddling the fence, particularly when political issues involve medicine. This is not necessarily a bad or weak position, because it makes movement in either direction not only possible but relatively easy. I refer to such issues as medicare, national health insurance, and immunizations. The official position of organized osteopathy during the political haggling over medicare was one of neither opposition nor support. When medicare was finally adopted as a public program, osteopathic care was recognized as the right of people to choose their physician, which was the only real concern of the osteopathic profession. Today, the inevitable national health insurance program is equally controversial, not so much as to its need but as to just which plan is to be adopted. Again the osteopathic profession is not directly involved politically, but it is watching the proceedings carefully in order to insure its proper role in any program involving the health of the nation.

Immunizations were once opposed by osteopathic physicians but are now generally accepted because they have been shown to be lifesaving in certain instances. The body has within itself the ability to build up its own immunity except when it is exposed to mass epidemics of infectious disease. Then, as **George W. Northup, D.O.**, points out in his book Osteopathic Medicine: An American Reformation,[2] the immunization procedure has the ability to "support and stimulate man's resistance against 'specific' infections." The recent, unfortunate reactions to the swine flu vaccine have, however, caused consternation among those involved in mass immunization programs, and the public is once again skeptical.

We could go on with the story of Dr. Still's personal and professional struggles and successes, but let us turn to the current status of osteopathic medicine. Politically, it has made great strides. It has outlived the amalgamation (with AMA) threat and such labels as "bonesetters," "drugless," and "the-same-as"; it is now recognized as one of the two complete schools of medicine; and it is better accepted and understood than ever before.

Clinically, the application of Still's principles to patient care is basically the same as it was when he lived. To most of us with a D.O. degree, the word treatment — now as then — means palpatory diagnosis and manipulative therapy as taught in our colleges and by physician-teachers in practice. We have, literally at our fingertips, a plus factor: emphasis on the human neuromusculoskeletal system. The importance of this part of the body was recognized first by Still. How it could have been ignored so long is a mystery, since it comprises 60% of the body and determines the blood and nerve supply to all other systems. Apparently, it was just too evident for the early physicians to see. Most of them looked upon each symptom as a disease entity rather than as an effect of an underlying cause. When they sought causes, they looked to forces outside instead of within the body itself. This attitude was not true of Hippocrates and his followers, however; they considered the man as well as the disease and nature as a healing power.

When an ambulant patient seeks help from an osteopathic physician, the D.O.'s attention is first directed to that person as a living, mobile being, the case history having been taken and preliminary questions answered. By observing how a patient stands, walks, sits, and lies down, the physician forms a preliminary opinion as to what is happening in that body at rest and in motion. This is followed by the physician's careful-meaning thoughtful-palpation of the body structures and corresponding soft tissues, with the patient seated, standing, or in a recumbent position. Still did much of his work with the patient standing, but each physician establishes a pattern that is best for him or her. This procedure will, of course, require modification for emergency and hospital patients, but modification

"To find health should be the mission of the doctor. Anyone can find disease."

largely in degree, not in principle. It need not change markedly whether the physician is a specialist or a generalist.

X-ray studies, when indicated, are a valuable tool for confirming certain palpatory findings, for pinpointing problem areas, and for disclosing pathology not palpable. Laboratory tests add a further dimension to diagnosis. Both x-ray and laboratory procedures are supplements to palpatory diagnosis, not replacements for it. Dr. Still did not have the advantage of these procedures and, therefore, relied entire-ly on what his hands and brain told him.

If structural variations are found in the examination, therapy should be directed to returning the body to a state as near normal as possible so that the blood and nerve supply is not obstructed. This can be done by manipulative techniques which each physician must develop from basic principles of anatomy and physiology and adapt to his or her particular body style and ability. Not every D.O. can be an Andrew Taylor Still any more than every lawyer can be a Melvin Belli, but almost everyone can master the principles of osteopathic manipulation sufficiently to

help all but the most difficult cases. There should be no hesitancy in referring such difficult cases to a colleague, if one is available, whose expertise in osteopathic management is recognized. It is for such cases, too, that other forms of treatment such as drugs, surgery, psychiatry, and physical therapy should be considered as conscientiously as osteopathic manipulation.

In connection with referrals, a recent development in the American Academy of Osteopathy is significant. Osteopathic physicians made fellows of the AAO through an earned fellowship can now be certified by the American Osteopathic Association as being proficient in the knowledge and use of osteopathic concepts and skills. Certification is not to be confused with specialization which would categorize the distinctive features of osteopathic medicine as a branch of the profession rather than what they are: the connecting links which run through all of osteopathic care of the patient as a whole. As time goes on and more men and women meet the requirements of this certification program and are properly identified, referral will be less of a problem than it may be at present.

In addition to helping the patient with a problem, osteopathy offers the only real and sensible approach to preventive medicine. Dr. Still said, "To find health should be the mission of the doctor. Anyone can find disease." The long-standing attitude of the public that the doctor is consulted only when one is ill is further encouraged by present policies of government and insurance agencies involved in health care. It is a vicious cycle that has to be broken at both ends: The public must be educated and physicians must be interested in preventive medicine. Economic factors will have to be dealt with in the educational process for everyone engaged in delivering health services, including third-party payers, which are paying most health care bills, at least indirectly.

Another objective of this educational process is to change patients' questions from "What do I take?" to "What do I do?" We have become a nation of pill-popping people. "To take" implies that there is a drug to counteract every symptom—a fallacious thought as we well know—whereas "to do" may imply a variety of therapeutic aids: dietary guidelines; a physical fitness program of walking, jogging, swimming, or bicycling; specific corrective exercises; or a cause to espouse. Considering all of the advantages of preventive medicine, it is ironic that, unfortunately, too many of our doctors are too busy treating acutely ill patients to spend time with the relatively well patient who wants to stay well. This dilemma needs study and research as much or more than some current projects.

"You can't intellectualize osteopathic manipulation. You have to do it."

Among the many advances made in our profession is the standardization of osteopathic nomenclature with reference to diagnostic findings. Osteopathic manipulative therapy defies standardization. Techniques vary from college to college, teacher to teacher, D.O. to D.O., and decade to decade. We have survived the pop and crunch eras, which were not all bad. As a matter of fact, 1 had just finished writing that sentence when the mail brought a brochure from the Chicago College of Osteopathic Medicine. On the first page was the headline "A winner, hands-down" and a commanding picture of two hands on a back. I read on: "What do Star Wars, the Chicago White Sox, the cruise missile, and CCOM's Osteopathic Medicine Department have in common? They're all hot. They're winners. Consider the following: Sixty freshmen turned out two times a week during the fall and winter quarters for Dr. Mark Walton's crunch clinic. These sessions were... completely voluntary and were 'hands-on' experience in the basics of osteopathic manipulation."

Here I am trying to update my terminology only to find that we have come full cycle and the word crunch is being bandied about by the young, both verbally and clinically. We are now heavily into muscle-energy philosophy and techniques which are not new, as their proponents readily recognize; they are adaptations of early techniques.

In **Dr. Arthur Grant Hildreth's** book The Lengthening Shadow of Dr. Andrew Taylor Still[3] there is the following description of a treatment of a patient with a cough and a sore spot at the head of the fourth rib: With the patient on his left side, the operator placed his knee at the angle of the fourth rib and his right hand on the sternal end of the rib. He then took the patient's right arm in his left hand, lifted it high, and then dropped the arm to the patient's side. The result was relaxation of tense muscles around a joint and relief of the cough. This treatment is a very simple illustration of what I understand to be the principle in the muscle-energy approach to manipulative therapy. Among its virtues is an important one, particularly for the new D.O.: It is almost impossible to hurt a patient using this approach.

Osteopathic medicine is a young, vital, growing profession. In today's scientific atmosphere, it has been

necessary apparently to make complex explanations of osteopathic therapeutics. It is not acceptable to say simply, "It works." It has to be proved — practically in a test tube, and osteopathic management of a patient cannot be measured by such a static measuring stick. To quote CCOM's **Mark Walton, D.O.**, "You can't intellectualize osteopathic manipulation. You have to do it."

The profession's main concern is to improve the system of health care available to the public, just as it was in Still's day. Its public acceptance has been remarkable considering its short existence, but there is no room for complacency. More colleges—if they can be adequately staffed in the clinical areas, more hospitals, more and better educational experiences, and more research are all needed. There are lesser matters—nuisance factors but important—to be dealt with in a constructive way, such as the D.O. designation which still needs explaining to the public. Difficulty with the pronunciation of osteopathy and inquiries about the abbreviation D.O. are not uncommon. The public relations departments of our national and state organizations, as well as other segments of our profession, are constantly providing information through literature, radio, and television, but it remains for the individual osteopathic physician to explain in detail and to demonstrate by his approach to patient care what D.O. really stands for. The question has changed from "How do you differ from a chiropractor?" to "How do you differ from an M.D.?" This reflects in some measure the change that has taken place in osteopathic practice in the last 25 years or more. Both questions need to be answered thoughtfully so as not to confuse the public further. Along with an explanation of the osteopathic approach to health and disease, the fact that the osteopathic profession is separate and distinct and intends to remain so must be implanted firmly in the minds of the inquirers. Most important of all, they must know that osteopathic medicine offers a unique alternative to the patient seeking health care.

In the early days, it was necessary for the pioneers of our profession to defend osteopathy in the courts, on the street, and in their offices. There is much less need to do so today. **Rod Kilpatrick**, KCOM class of 1979, expresses this trend well in an article entitled Why Defend Osteopathic Medicine? The last paragraph sums up his thinking and, I assume, the thinking of the student body in general since he is president of the Student Government Association: "Think about it," he writes. "And instead of feeling that you have to go out into the world and defend our profession, let's go out there to practice and promote the best medicine we know how, and the profession's defense will take care of itself. After all, osteopathic medicine wouldn't still be around after nearly one hundred years if it didn't have a good thing going." (Actually, osteopathic medicine has been around a little longer than a hundred years.)

The D.O. degree represents an accomplishment and a dedication to be proud of, to enjoy, and to use not only officially on stationery, signs, and signatures, but even socially as identification of a chosen profession. In June, I was at Lake Baikal in Siberia with a group of eight men and women. One man was an M.D., and at lunch one day I referred to my D.O. degree. He said, "Well, that is very interesting. Both of my parents studied at Kirksville in the early 1900's and I was delivered by Dr. Still." This is not to suggest that you have to go to Siberia to find someone who is familiar with the D.O. degree, but rather that its identification often leads to unexpected and interesting experiences. Most people with whom we come in personal contact are eager to learn, or learn more about, osteopathic medicine.

Those of us holding the D.O. degree are obligated to walk that extra mile for both our patients and our profession. It is important to support osteopathic organizations by membership and active participation. It is even more important to conduct the kind of practice that is identified with the degree which we hold. I am convinced that any kind of manipulative treatment based on osteopathic principles and given with discretion, whether it is so-called "engine-wiping" or "give 'em hell in the upper dorsals," is better than no manipulation at all. It is highly probable that a large percentage of patients have tried other doctors before they consult an osteopathic physician. This makes it more important than ever that we utilize our unique approach, because patients can get the other kind of treatment anywhere. All of us with a D.O. degree must "try the best first," that is, osteopathic manipulative therapy preceded by palpatory evaluation of the musculoskeletal system. In so doing, we will adhere to another of Andrew Taylor Still's aphorisms, "Remove all obstructions, and when this is intelligently done, nature will do the rest." ❑

References

1. Tucker, Ernest E., and Wilson, Perrin T.: The theory of osteopathy. The Journal Printing Company, Kirksville, MO, 1936

2. Northup, George W.: Osteopathic medicine: An American reformation. American Osteopathic Association, Chicago, 1966

3. Hildreth, Arthur Grant: The lengthening shadow of Dr. Andrew Taylor Still. The Journal Printing Company, Kirksville, MO, 1938

Dr. Astell is a graduate of KCOM (1945) and was an assistant professor of osteopathic manipulative therapy there from 1969 to 1974. She is a past president of the American Academy of Osteopathy. Dr. Astell is now retired and lives in Escondido, CA. She delivered the Scott Memorial Lecture on 10 October 1977.

Case Study
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2. Acute and chronic somatic dysfunction in the thoracic and lumbar regions.

Osteopathic manipulative therapy was rendered utilizing HVLA techniques as well as muscle energy and myofascial release techniques. The cervicothoracic transitional area was found to be quite restricted, however, this was mobilized well with thrust technique. The patient was instructed to return in three weeks for reevaluation. At that time, she was found to have significant improvement of her symptoms. The patient was seen on three additional occasions at three week intervals, at which time her shoulder pain was resolved and she was discharged.

Discussion:

The first rib is quite short, broad, and flat. The only vertebra with which it articulates is Tl. The first rib attaches to the manubrium through the costal cartilages via a synchondrosis type of joint. The remainder of the chondrosternal joints are diarthrodial joints with synovial linings. Because of these anatomical relationships, distortion of Tl will have a profound effect upon the position and motion of the sternum, and hence, the entire upper thoracic cage. The only bony articulation of the shoulder girdle with the axial skeleton occurs at the sternoclavicular joints. Because of their relationship to the first chondrosternal joints and the presence of the costoclavicular ligaments, distortion of the sternum through Tl dysfunction will cause displacement of the sternoclavicular joints and result in a change in the motion characteristics of the upper extremities bilaterally. Unleveling of Tl must lead to compensating changes in the motions of the lower cervical vertebrae which are the sites of origin of the nerve supply to the scapular stabilizing muscles. Therefore, from a biomechanical point of view, this patient's initial dysfunction in the upper thoracic region led to a series of changes in the motion characteristics of the upper extremities through the shoulder girdle.

The glenohumeral area contains a large number of relatively avascular structures. Once an inflammatory process has been initiated, any impediment to oxygen delivery to these structures will tend to prolong the duration of the inflammatory process. Distortion of the cervicothoracic transitional area and the superior thoracic aperture can cause an impediment to venous and lymphatic return. Passive congestion can easily develop in the anterior and posterior axillary folds. This build-up of waste products in the cellular environment continues the inflammatory process as well as impeding the normal delivery of oxygen to the tissues. Pain in the shoulder area leads to voluntary restrictions of movement. This lack of muscular activity in the area also decreases the pressure gradient from the upper extremity to the thoracoabdominal cavity that is created by muscular contraction.

This case illustrates the importance of the T1-first ribmanubrium complex as it relates to inflammatory conditions of the glenohumeral area, both from the biomechanical and respiratory circulatory points of view. The osteopathic manipulative management of these patients, therefore, must focus on the normalization of structural relationships as well as *insuring* an optimal thoracoabdominal pressure gradient to allow improved delivery of oxygen to the area. Enhancing the removal of waste products from the cellular environment as well as optimizing the structural-functional relationships should allow the body's inherent capacity for self-healing to be expressed. ❑

Academy Leadership
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medicine. HCFA has appointed AAO President-elect **Herbert A. Yates, D.O.** to this Advisory Committee where he can represent Academy members.

At the 1992 Convocation, the Board of Trustees established an Ad Hoc Committee on Federal Regulation of Osteopathic Manipulative Medicine. The Chairman **Richard Feely, D.O.** and members include **Drs. O'Connell, Yates, Judith Lewis, D.O.**, and **Raymond Hruby, D.O.** One of the first actions of the Committee was to adopt a definition of OMT which is:

> *Osteopathic Manipulative Treatment is the application of one or more manual techniques by an osteopathic physician and surgeon to a patient's musculoskeletal system and/or other body system(s) to alleviate somatic dysfunction and/or somatic components of disease.*

The Dayton Academy of Osteopathy agreed to advocate this definition at the Ohio Osteopathic Association's annual convention with the intent of forwarding a recommendation for adoption to the 1992 House of Delegates of the American Osteopathic Association.

The Ad Hoc Committee also has contracted with a professional market research firm to design a comprehensive AAO membership survey to document the extent and use of OMT in professional practice, the use of MO-codes vs. CPT codes for osteopathic manipulation, the average time spent with patients, continuing medical education issues, and other AAO membership matters. The intent of the survey is to establish baseline data which can be used in advocating proper reimbursement for professional services as well as in designing educational programs and membership services for AAO members. ❑

REPORT OF DOUG WARD, PH.D., DIRECTOR, AOA DEPARTMENT OF EDUCATION

Dr. Ward informed the Bureau of his recent discussions with D.O.s in various provinces in Canada. He reported that the Medical Counsel of Canada has revised its bylaws and will now allow American-trained D.O.s to sit for the Licentiate of the Medical Council of Canada (LMCC) written exam. Upon successful completion of this exam, the individual D.O. would have full licensure rights in any of the Canadian provinces.

Recognition goes to **David Welch** and **Michael Boardman** for the graphics and to the Kirksville College of Osteopathic Medicine (KCOM) Chapter UAAO, and the KCOM Audio Visual Department for their assistance in helping **Michael Kuchera, D.O.** create our cover slide, and slide used on page 7.

The World Health Organization (WHO) Collaborative Training Center in Beijing, China, is now accepting applications for its 3-month and 6-month intensive acupuncture training programs. The programs will include both theoretical basis and clinical practicum. For further information, please contact: Dr. Kenneth Lubowich, Director, China Academy of Traditional Chinese Medicine, U.S. Foreign Office, 8839 Knox Avenue, Skokie, IL 60076, (708) 676-9891.

CALENDAR OF EVENTS

June 19-21, AAO International Symposium, Cincinnati, OH

June 20-28 — 6/20-24/92 - Basic Course in Osteopathic in the Cranial Field - Sir Francis Drake Hotel, San Francisco, CA. 6/26-28/92 - Annual Conference, As the Twig Is Bent - Sir Francis Drake Hotel, San Francisco, CA. Contact: Madeline Rathjen, (208) 888-1201. P.S. Please do not make travel arrangements until you are accepted.

June 25-28 — Illinois Association of Osteopathic Physicians and Surgeons, Annual Convention, Hotel Pere Marquette, Peoria, IL. Contact: Jenise L. Nanni, (815) 434-5576

June 25-28 — Ohio Osteopathic Association 94th Annual Convention, Drawbridge Inn, Cincinnati, Ft. Mitchell, KY. Contact: Jon F. Wills, (614) 299-2107

June 25-28 — Osteopathic Physicians and Surgeons of Oregon Annual Convention, Sunriver, OR. Contact: Jeff Heatherington, (503) 244-7592

June 26-29 — Colorado Society of Osteopathic Medicine, Annual Convention, Colorado Springs, CO. Contact: Patricia Morales, (303) 322-1752

June 28 - July 1 — Washington Osteopathic Medical Association, Annual Convention, Celebrating 100 Years of Osteopathic Medicine, Inn at Semiahmoo, Blaine, WA. Contact: Kathie Itter, (206) 937-5358

July 10-12 — Massachusetts Osteopathic Society Annual Summer Convention on Cape Cod, Ocean Edge Resort, Brewster, MA. Contact: Michael Shay (508) 896-7247

July 10-12 — AAO meeting, Hilton, Dayton , OH

July 14-19 — American Osteopathic Association Annual Business Meeting of the Board of Trustees and House of Delegates, Hyatt Regency, Dearborn, MI. Contact: Ann Witner, (800) 621-1773, ext. 5814 or (312) 280-5814

July 23-26 — New Mexico Osteopathic Medical Association, 55th Annual Convention, Clarion Inn Eldorado, Santa Fe, NM. Contact: Richard W. Saiser, (505) 828-1905

August 7-9 — AAO Ed Com meeting, Adams Mark Hotel, St, Louis, MO

August 7-9 — UAAO Council meeting. Adams Mark Hotel, St. Louis, MO

August 19-23 — Part I: Intro to Esoteric Healing sponsored by The International Health Research Network, Park Inns International Hotel, E. Lansing, MI. Contact Dr. Barbara Briner (517) 349-7377 after 7pm E.S.T.

September 10-13 — New England Osteopathic Assembly, New Hampshire.

September 11-13 — AOA Osteopathic Graduate Medical Education Leadership Conference, Chicago

September 19-23 — AOHA Convention, New Orleans

September 24-27 — OMT Update and Bid Review, Walt Disney World, FL

October 4-10 — National Osteopathic Medical Week

October 9 — AOA Council on Fed Health Prog., Washington D.C.

November 1-5 — AOA Annual Convention, San Diego, CA

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structured to serve several specific functions, the structure of your recycling system determines how efficiently it functions. The osteopathic approach teaches us to examine structure for its suitability to provide the desired or necessary function; where dysfunction is found, modification of structure is considered.

Chapter's Challenge

Each chapter is encouraged to develop and implement a plan for contributing to the UAAO national project. Recognize that osteopathic education should be the center of each chapter's project in commemoration of the centennial while the effectiveness of this educational program should be recorded by the increase in recycling efforts in your institution and community.

Chapters are encouraged to interface with existing institutional and community recycling programs and to fill the void where deficits are found. Encourage all UAAO members and their families to become involved; enlist the aid of your osteopathic teaching departments and the teaching departments and the teaching hospitals associated with your institution.

Recently, the AAO Board has passed a resolution that Academy members would be encouraged to support the UAAO in this project, so also feel free to approach members of the AAO to help in the implementation of your projects.

The Future

With regard to health care we would like them to think: D.O. it for your world, D.O. it for yourself!"

Join the UAAO and the AAO in a united approach to this function. ❑

REGISTER NOW!

SECOND ANNUAL OMT UPDATE

Application of Osteopathic Concepts in Clinical Medicine
and
Preparation for OMM Boards
September 24-27, 1992

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