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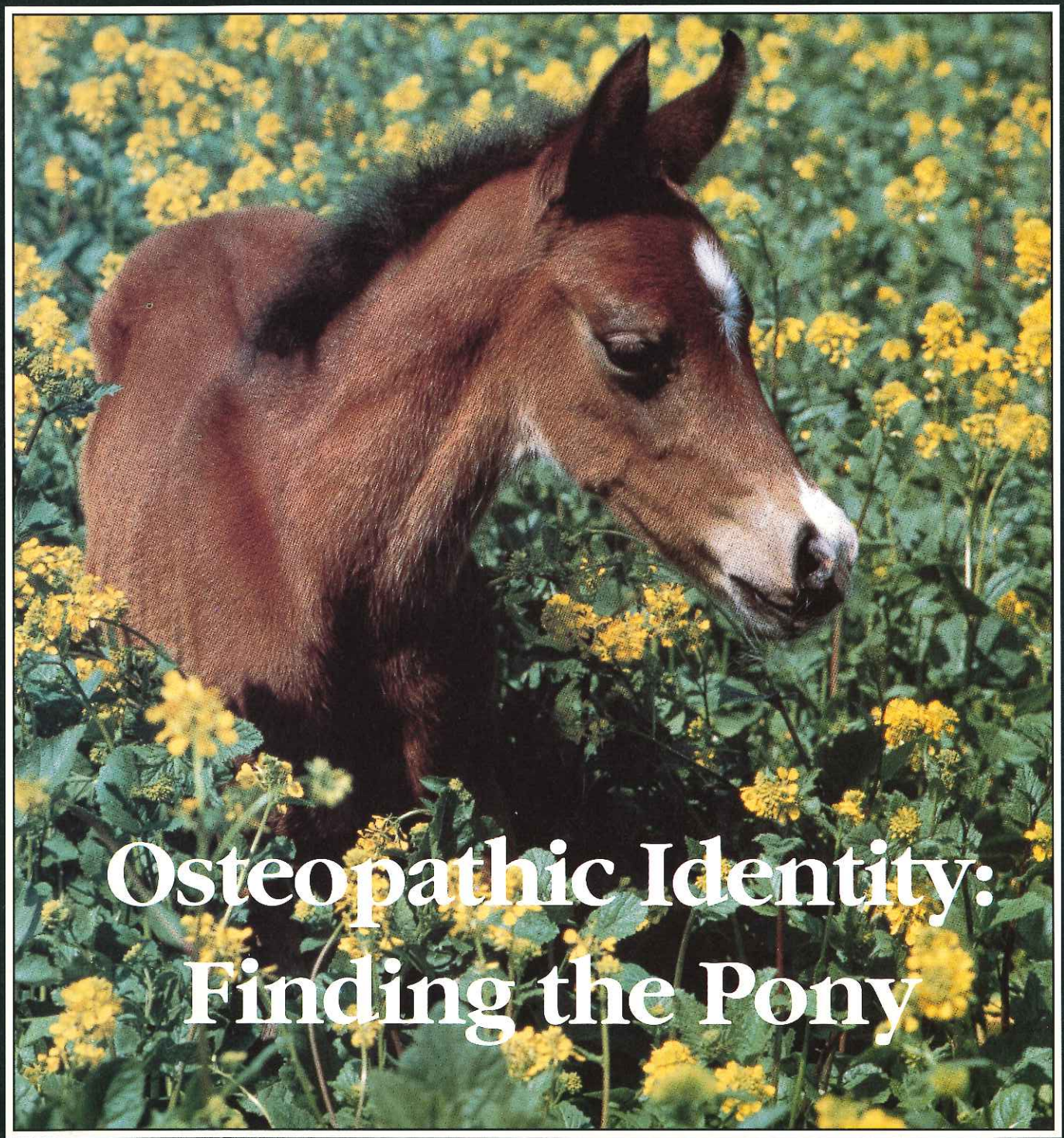

Osteopathic Identity: Finding the Pony

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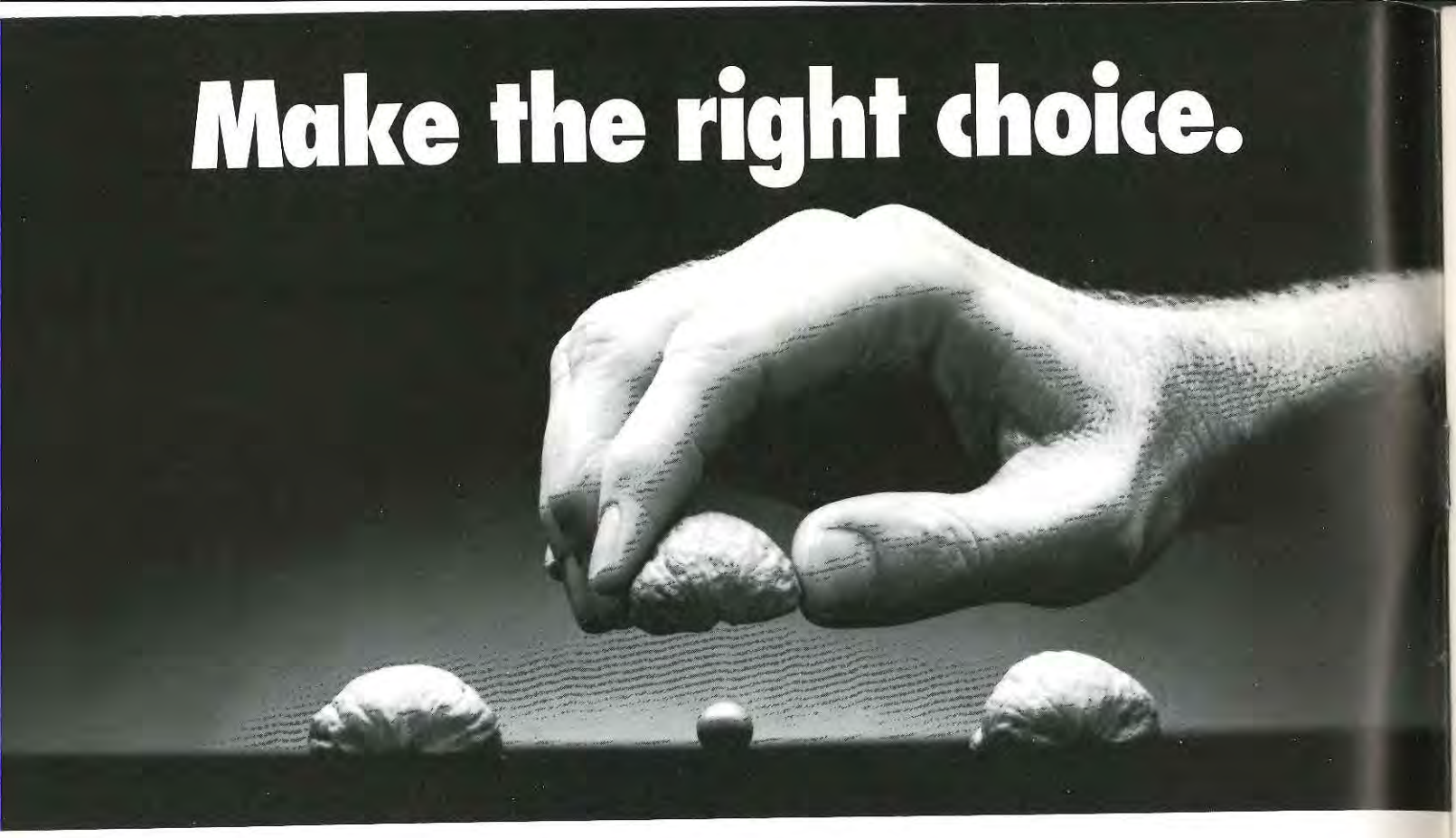

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The mission of the American Academy of Osteopathy is to teach, explore, advocate, and advance the study and application of the science and art of total health care management, emphasizing palpatory diagnosis and osteopathic manipulative treatment.

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From the Editor

Using Your Wounds

As I write this, I have just returned from this year's AOA Convention in Boston. The Convention was a pretty busy scene this year: so busy that I found it impossible to really attend all the events that interested me.

One event that was particularly interesting, however, was the excellent presentation made by Dr. Bernie Siegel at the AAO Convention program. I managed to attend a good portion of Dr. Siegel's presentation and found it to be very enlightening.

He spoke about a lot of things, but there was one item that particularly stuck with me as I left the lecture hall. Dr. Siegel talked about "using your wounds". By that he meant that we are all "wounded" emotionally in various ways as we proceed through life. Life hands us a lot of twists and turns that aren't always fair, and how we deal with these makes a big difference in the kind of person we become. His point was that if we think about it long enough, life's setbacks can always be turned into positive progress. It all depends on how we look at each individual event. So when we are "wounded", that is when something goes wrong, when somebody hurts your feelings or insults you — whatever the situation, we have a choice: we can either become angry, frustrated, bitter, full of self-pity or some other such thing or we can use the opportunity to better ourselves and others. In other words, as the saying goes, when life hands you lemons, make lemonade!

As I thought about this concept, I began to wonder about the kinds of "wounds" the osteopathic profession has suffered over the years. Certainly if we look at the history of the profession we can see any number of instances of discrimination against osteopathic physicians, ignorance of the nature of osteopathic medicine and other similar problems. I'm sure we have all encountered someone who professes that osteopathic physicians aren't really doctors, that their training is inferior or some other such comment.

What can we do when things like that happen? Again, if we follow Dr. Siegel's thought, we have at least two choices: 1) we can be angry about it; being angry at the person who would make such a statement or angry at the AOA because we think they're not informing the public enough about our profession or; 2) we can feel frustrated, depressed and just go away and do nothing.

But there is another solution. We can turn these kinds of situations into positive experiences for ourselves and our profession. So if somebody says something disparaging about the profession, or something that reflects ignorance on their part, it would be a good idea to take the time to educate that person. Not only would you educate them, but you might even gain a friend out of the deal! And you would certainly feel better about the whole situation.

I would suggest, however, that if you decide that this is how you're going to handle these situations in the future, it would be best if you do a little preparatory work. What I mean is, you must be sure you know how to answer questions about osteopathic medicine, about the profession. Can you explain osteopathic concepts in a brief but understandable way? Do you know how many DOs there are? How many osteopathic colleges? How many osteopathic hospitals? How many students we graduate each year? What fields of practice do they enter? What are the licensing requirements?

These are only a few of the questions that come to mind. I'm sure you can answer them, but I find it helpful to think about these things a little, and if there is something I don't know, it's best to find out before somebody challenges you.

So, I would urge you to make the best of these situations, and "use your wounds" to better educate people about yourself and your profession. You will find yourself feeling that you are better off for having made the effort! ❑

Mark Your Calendar

June 18-22, 1994
Basic Course in Osteopathy in the Cranial Field
40 Hours CME Anticipated

June 23-26, 1994
Explorations in Osteopathy
(Clinical Correlations of Facial Structure and Function)
20 Hours CME Anticipated

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INSTRUCTIONS FOR AUTHORS

The American Academy of Osteopathy (AAO) Journal is intended as a forum for disseminating information on the science and art of osteopathic manipulative medicine. It is directed toward osteopathic physicians, students, interns and residents and particularly toward those physicians with a special interest in osteopathic manipulative treatment.

The *AAO Journal* welcomes contributions in the following categories:

Original Contributions

Clinical or applied research, or basic science research related to clinical practice.

Case Reports

Unusual clinical presentations, newly recognized situations or rarely reported features.

Clinical Practice

Articles about practical applications for general practitioners or specialists.

Special Communications

Items related to the art of practice, such as poems, essays and stories.

Letters to the Editor

Comments on articles published in *The AAO Journal* or new information on clinical topics.

Professional News

News of promotions, awards, appointments and other similar professional activities.

Book Reviews

Reviews of publications related to osteopathic manipulative medicine and to manipulative medicine in general.

Note: Contributions are accepted from members of the AOA, faculty members in osteopathic medical colleges, osteopathic residents and interns and students of osteopathic colleges. Contributions by others are accepted on an individual basis.

Submission

Submit all papers to Raymond J. Hruby, DO, FAAO, Editor-in-Chief, University of New England, 11 Hills Beach Road, Biddeford, ME 04005.

Editorial Review

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

Requirements for manuscript submission:

Manuscript

1. Type all text, references and tabular material using upper and lower case, double-spaced with one-inch margins. Number all pages consecutively.

2. Submit original plus one copy. Please retain one copy for your files.

3. Check that all references, tables and figures are cited in the text and in numerical order.

4. Include a cover letter that gives the author's full name and address, telephone number, institution from which work initiated and academic title or position.

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Illustrations

1. Be sure that illustrations submitted are clearly labeled.

2. Photos should be submitted as 5" x 7" glossy black and white prints with high contrast. On the back of each, clearly indicate the top of the photo. Use a photocopy to indicate the placement of arrows and other markers on the photos. If color is necessary, submit clearly labeled 35 mm slides with the tops marked on the frames. All illustrations will be returned to the authors of published manuscripts.

3. Include a caption for each figure.

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References

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

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

Editorial Processing

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

To The Editor

Dear Dr. Hruby,

Several weeks ago I was struck on the tip of my lower jaw. The approximate location was the mental process of the mandible and the blow was delivered by a wild, upward follow through of a squash racquet, a mechanism closely resembling an uppercut to the jaw. Aside from the local swelling and laceration I experienced immediate sharp pain in the region of both TMJ's as well as pain upon opening and closing my mouth. I also noticed that I could not close my mouth; my upper and lower incisors met but my molars could not be made to touch. It was as if my lower jaw were thrust forward.

After two days I became quite concerned that I had experienced some permanent damage, but in thinking through the anatomy, it did not appear to be an articular or skeletal injury. I remembered that the external pterygoid muscle by contracting pulled the lower jaw forward and opened the mouth, just what appeared to be happening to me. I reasoned that the blow suddenly stretched these muscles, causing them to react by spasming into a constant contraction. If my theory was correct, I thought I should be able to alleviate the symptoms using a muscle energy technique.

So using both palms I pushed my lower jaw posteriorly as far as it would go and then thrust my lower jaw anteriorly against the pressure of my palms for five seconds. Then I relaxed and pushed my lower jaw posteriorly and repeated the procedure five times. To my surprise I was able to close my mouth and open and close it with very little pain.

One would expect that this would be a relatively frequent type of injury. I offer this technique not only to help alleviate symptomatology but also as a testament to the relationship of structure to function. I would like to thank Boyd Buser, DO and Steve Hartman, PhD for their instruction in anatomy and manipulative therapy which enabled me to open and close my mouth and speak again so quickly, something others may not appreciate as much as I do.

Sincerely,
Fred R. Fenton
UNECOM Class of 1994

(l-r) Walter Ehrenfeuchter, DO, FAAO; Bernard Siegel, MD and AAO President Herbert Yates, DO visit outside of the AAO lecture hall during the 1993 AOA Convention in Boston.

Message from the President

Who are we? Where are we going? Why should any of us care enough to be involved? Who are we? We are the American Academy of Osteopathy. What is that? We are the true believers and practitioners of the art and science of osteopathy. Some say we are eccentric, fringe, and that we hold on to the past.

Eccentric? — Maybe — We do tend to be independent, patient oriented health seekers who look at alternatives to the ineffective symptom treating, drug and procedure based practitioners. However, "mainstream medicine" is increasingly looking to these traits as "alternative" medicine and accepting and espousing them. These traits have been ours for over a century.

Fringe? — The difference between the fringe and the cutting edge is only the direction one is going. When the direction changes toward the fringe, the fringe becomes the cutting edge. When Semmel Wies insisted that doctors wash their hands before surgery and obstetrical delivery, he was considered lunatic fringe; however, his philosophy became the cutting edge of medicine as it remains today. If one knows and practices the truth, one may be thought to be on the fringe. Eventually, as the body of medical thought moves toward accepting that truth, instead of the fringe, one will be the cutting edge.

Holding onto the past? — Consistently holding to the practices and truths that have stood the test of time and not being swayed by the fashionable practices of what is in vogue seems reasonable rather than outdated to me. Yet I often see DOs looking in a distorted social mirror saying I must be second best, not as good as and feeling inferior — yet we are primary care and high touch. We are what America and the world needs. We are truly the only fully trained physician in this country and we do bridge the gap between traditional and alternative health care. Yet we keep our secret. Some DOs keep the secret and feel inferior because looking in this distorted social mirror is much like looking in a mirror in a fun house. It is funny if you don't take it seriously, but tragic if you accept this image as true. This inferiority image is a projection and not a true reflection. The antidote for this false projection, this poisoned self image is affirmation of our worth and potential by others. Gothe once said, "Treat a man as he is and he will remain as he is. Treat a man as he can and should be and he will become what he should be." This is a lesson that we both need to learn and apply to ourselves and to teach our patients.

We are the best examples of balanced health care delivery in the world. When we realize it and act like it, we will become recognized as being the best. If, as a profession, we keep looking in the distortion mirror to gain a view of ourselves, we are doomed. We must see ourselves as we are. We need an accurate guide to direct us through these challenging times.

A mission statement serves as a compass to lead and guide us not just a representative map because maps can be wrong. For example, if we came to Boston with a map of Chicago that was labeled as Boston, we would be unable to find our way because our behavior follows our map. Thus if we have the wrong map, our behavior will not lead us toward our goals. If we have the wrong map and we follow the work ethic, that is we work harder, we are still lost but we are getting lost twice as fast. If we have a positive mental attitude and try to find our way with the wrong map, we are lost but we don't care. We must have accurate maps based on our values and our values are stated in our mission statement:

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

I believe these are values and principles that can serve as a map and a compass to guide us as we move forward. Do we have a clear knowledge of who we are and a clear picture of where we want to go? I believe we do. We believe the human body is a unified organization and this gives us the practice that is holistic, common sense oriented and views the patient in his or her entirety. We view the musculoskeletal system as central to a person's well being and we apply this by our many proven techniques of hands on diagnosis and treatment. We can often provide an alternative to more intrusive therapy involving drugs and/or surgery. We have a challenge in this area to work with and allow others in physical medicine to complement us. The body has a natural tendency to self healing, as well as a capacity to resist disease. We have served as pioneers in wellness by the practice and mentality of using nutrition and fitness and helping every patient function to his or her optimum. We have done this for over a century. If we stay true to our values and principles we will continue to go forth successfully, and to go forth Osteopathically. ❑

Herbert AYates, DO, FAAO

❑

Message from the Executive Director

Stephen J. Noone, CAE

AMA Publishes 1994 CPT Manual

The American Medical Association has published its 1994 CPT' Manual, which includes codes for osteopathic manipulative medicine as negotiated by AOA Representative **Judith O'Connell.** However, the preamble to the listing of the OMT codes is not exactly what Dr. O'Connell had negotiated with the CPT Editorial Panel and what had previously had been reported by the Academy. At this time, she and the AOA leadership are pursuing the matter with the AMA to determine what happened between the agreement and publication.

Nevertheless, the good news is that the OMT Codes are in the 1994 CPT Manual and the AOA's Work Group on Coding currently is preparing an instructional manual for distribution to every DO in the country. I encourage you to work with your state osteopathic associations to ensure that all third party payors receive information on these new codes and agree to implement reimbursement procedures beginning January 1, 1994.

AOA Addresses Credentialing Problems

To better protect the practice rights of its members, the American Osteopathic Association has added a paralegal to act as point person for credentialing issues. **Jacquelyn Slick,** Special Projects Coordinator within the AOA Communications Department, handles hospital staff privileging cases for the AOA and tracks managed care calls directed to AOA's Chicago and Washington offices. Shifting a portion of the casework to Chicago affords the Washington staff more time for government relations activities on behalf of the osteopathic profession. And, involving AOA Communications staff in this casework assists them in developing pro-active public relations programs to key decision-makers.

Each call to the AOA from physicians who experience difficulty in defending their osteopathic training presents a new opportunity to educate the public and the health care community. Sometimes hospitals or employers simply need to see on paper that DOs are recognized by the federal government. They frequently request written proof that osteopathic training meets standards equivalent to allopathic education.

Once staff receives a call or letter, necessary paperwork is filled out for AOA files. Preliminary letters and documentation are sent to the person or institution presenting the perceived discrimination against a DO. Sometimes these educational letters resolved the problem immediately. In recent months, two hospitals have decided against changing their bylaws to revoke recognition of osteopathic training. Four hospitals have granted staff privileges to physicians once the credentialing committee saw the equivalency of osteopathic medicine under the law.

Presently the AOA Chicago and Washington offices are developing new strategies for dealing with those hospitals and managed care bodies that are slow to recognize osteopathic training and certification. Staff is looking for patterns in successful cases and documentation that conclusively convinces hospitals, HMOs and PPOs of the high quality of osteopathic medical training.

The AOA welcomes calls from physicians who feel they are experiencing discrimination. Contact with these types of problems also helps in the development of an AOA manual on credentialing that will help practice affiliates and divisional societies to deal with these problems directly. If you are experiencing a challenge to your credentials, please contact Jacquelyn Slick, Special Projects Coordinator at 1-800-621-1772, extension 7430. (Source: *For AOA Members Only*, October 1993)

NIH/OAM Publishes Newsletter

AM is the title of NIH's Office of Alternative Medicine's bi-monthly newsletter, first published in September 1993. The initial issue reviewed the office's establishment and call for research grant proposals. You can get on the mailing list by writing to:

Office of Alternative Medicine
National Institutes of Health
Building 31, Room B-C35
Bethesda, MD 20892

One significant note was the solicitation of reader contributions. If you have contributions for the newsletter, send your manuscripts, calendar notices, along with a single addressed stamped envelope to:

Editor, *AM*
5517 Trent Street
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❑

1993 Thomas L. Northup Lecture

AAO President Herbert A. Yates, DO, FAAO, presents the 1993 Thomas L. Northup Award to Raymond J. Hruby, DO, FAAO on October 13, 1993, in Boston. Dr. Hruby's Northup Lecture follows:

Osteopathic Identity: Finding the Pony

by Raymond J. Hruby, DO, FAAO

There were once two brothers, one of whom was an incurable pessimist and the other an incurable optimist. One year, on Christmas day, the pessimist was given a room full of shiny new toys and the optimist, a room full of horse manure. The pessimist opened the door to his room full of toys, sighed and lamented, "A lot of these are motor driven and their batteries will run down; and I suppose I'll have to show them to my cousins, who'll break some and steal others; and their paint will chip; and they'll wear out. All in all, I really wish I hadn't gotten this room full of toys!" The optimist opened the door to his room full of horse manure and, with a shout of glee, threw himself into the muck and began burrowing about in it. When his horrified parents extricated him from the excrement and asked him why on earth he was thrashing about in it, he joyfully cried, "With all this horse manure, there's got to be a pony in here somewhere!"[1]

We often speak of the 'osteopathic identity'. But trying to define what is meant by this osteopathic identity is a lot like finding the pony in the midst of a lot of extraneous stuff. The term 'osteopathic identity' has been used by more than a few osteopathic physicians to refer to our professional uniqueness. Since the time of Dr. Still the osteopathic profession has grown, developed, evolved and become more complex. Logically, what we refer to as the osteopathic identity has done the same. In fact, we may be a profession still in search of its full identity, its place in the world of medicine.

In all of this complexity, then, how do we "find the pony"? That is to say, how do we determine just what is the osteopathic identity to which we so often refer? I hope to share with you some of my own ideas about osteopathic identity. Specifically, there are three points I would like to make in this regard: first, there is indeed such a thing as an osteopathic identity; second, there are reasons as to why it is so difficult to define or recognize; and third there is something we can do about this situation.

Before we characterize an identity as being osteopathic, let us explore for a moment the concept of identity itself. What is an identity? How is one's identity formed? How do we know who someone is?

Simply put, our identity consists of the beliefs we use to define our own individuality, that which makes us unique from others. This system of beliefs gives us a sense of certainty about who we are; and this sense of certainty about who we are allows us to create the boundaries and limits within which we live our lives. Furthermore, these beliefs are based not on our experiences but on the interpretation we give to our experiences. There are some other things we should know about this concept of personal identity. First, research has shown that a person's capabilities are powerfully influenced by the identity developed by that person. As a kind of corollary to this, we must also recognize that the kind of person others believe you to be will influence their responses to you. Second, understanding that there is a basic human need for consistency, we all tend to act consistently with our views of who we truly are, regardless of whether or not this view is accurate. Finally, how do we know who a person is? The answer is that we identify someone by his or her actions. To put it another way, we look at what we do to define who we are.

We can apply these definitions and principles regarding personal identity

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[1]Adapted from the story told in Sackett DL, Haynes RB, Guyatt GH, Tugwell P: Clinical Epidemiology: A Basic Science for Clinical Medicine, Second Edition. Boston: Little, Brown and Company, 1991, p. 13.

to the concept of osteopathic identity. If personal identity is based on certain beliefs we have about ourselves, then it seems logical that our osteopathic identity is based on beliefs we have about osteopathic medicine. And if a person is identified by others by his or her actions, then we, as osteopathic physicians, are likewise identified by certain actions. Let us see, then, if we can clarify for ourselves the osteopathic identity by answering the following questions:

What beliefs do we have about osteopathic medicine?

Osteopathic medicine is based on several beliefs:

1) The body is a unit.

2) The body has self-regulatory and self-healing capabilities.

3) Structure and function are interrelated.

4) Rational treatment is based on the application of the above principles to the total care of the patient.

What actions do we take by which we demonstrate these beliefs, and by which we can be identified as osteopathic physicians?

There are several actions that osteopathic physicians take that exemplify osteopathic principles in action. They include, but are not necessarily limited to, the following:

1) Our knowledge of anatomy and our ability to express and apply that knowledge has always been greater than that of other health care professions.

2) Many patients express their satisfaction with the more humane bedside manner typical of the osteopathic physician.

3) Emphasis on family practice and primary care has been a hallmark of the osteopathic profession.

4) Another recognizable distinction is the emphasis we place on preventive medicine and wellness.

5) Finally, osteopathic manipulation has been one of the most visible means by which one can be recognized as an osteopathic physician.

And so the process of expressing our osteopathic identity would seem to be very simple: we have a set of beliefs (principles), and based on those principles we carry out certain actions by which we are easily identified as osteopathic physicians. But if this is true, why then do we have so much trouble with the idea of describing or demonstrating this identity, this uniqueness that we know exists?

The answer, I believe, is that there is oftentimes an inconsistency between what we practice and what we preach. This is a phenomenon that Peter Senge[2] refers to as "Espoused theory versus theory-in-use". That is, there is a gap between what we say and the theories that govern our actions. For example, I may say (an espoused theory) that people are trustworthy, but if I never lend anything to anyone then my theory-in-use is quite different from my espoused theory. Likewise, if I am an osteopathic physician and I say that I believe in the principles of osteopathic medicine listed above, yet I perform none of the actions that would identify me as an osteopathic physician, there is a gap between my espoused theory and my theory in use.

The theory-in-use, then, is based on a mental model, and mental models are formulated by our interpretations of our experiences. So now we may ask:

What experiences have we had that helped to shape these beliefs?

Those osteopathic physicians who are clearly identified by their actions have obviously had experiences which led them to fully identify their osteopathic identities. These experiences most likely occurred during the time when they were students, that is, during their undergraduate and postgraduate osteopathic medical training. These students had role models who were able to explain osteopathic principles to them in a clear and credible manner. These same role models were able to teach these students how to apply osteopathic principles, including osteopathic manipulation, in an appropriate and effective manner. These students had successful and

[2]Senge, PM: The Fifth Discipline: the Art and Practice of the Learning Organization. New York: Doubleday, 1990, p. 202.

positive experiences in their attempts to apply these principles in the care of their patients, and these experiences caused them to want to gain even more expertise as truly osteopathic physicians. In other words, they were able to interpret their experiences in a way that led to the formulation of a set of beliefs and actions clearly identifying them as osteopathic physicians.

Obviously those osteopathic physicians who are not readily identified as such did not have the same experiences as students, or at least were not able to interpret their experiences as the students just described. Instead, they formulated a set of limiting beliefs that cause them to either reject osteopathic principles and actions altogether, or, perhaps even worse, espouse the principles but perform no actions that demonstrate that espousal.

What kinds of limiting beliefs do these osteopathic physicians have that keep them from performing "osteopathic actions"? Based on an informal survey of some of my colleagues, a number of limiting beliefs were elicited. The most frequently mentioned ones were as follows:

1) "I don't have enough time for things like OMT."

2) "There isn't enough scientific evidence to support the value of osteopathic principles."

3) "I can't get paid for it."

4) "I don't feel skilled in manipulative methods because I wasn't taught well enough in school."

Similarly, some osteopathic physicians didn't feel skilled enough because they were not given the opportunity to use their manipulative skills during their clerkship rotations or their postgraduate years and they subsequently lost their ability to perform these skills.

There certainly may be other limiting beliefs held by some osteopathic physicians, but these were the most common ones expressed to me. What can be done about all of this? Earlier we said that there indeed was such a thing as an osteopathic identity, and we listed the principles and the actions by which such an identity could be recognized. We said there were still some osteopathic physicians who, because of the way they came to interpret their educational and practice experiences, had not developed a clear osteopathic identity of their own. We also said there were steps we could take to correct this problem. So what can be done? These are some of my suggestions:

First, know your own osteopathic identity.

Take the time to clearly define who you are osteopathically. How much do you really know about the osteopathic principles we mentioned earlier? What do you really believe about these principles? If you had an osteopathic ID card that described who you truly are, what would be on this card? What would you rather *not* see on this card? If there were an Encyclopedia of Osteopathic Physicians, what would it say about you? Would it take only a few words, or would it require any number of pages or even a separate volume of your own?

Second, take the time to examine the kinds of actions you perform that identify you as an osteopathic physician.

Examine your interpersonal skills, your bedside manner. How well do you establish rapport with your patients? How much time do you spend educating your patients about disease prevention and wellness? How much osteopathic manipulative treatment do you do and for what kinds of conditions? How much more could you do? An easy rule to follow is to ask yourself four simple questions every time you see a patient:

1) Have I considered the whole patient?

2) Have I done everything I can to optimize this person's self regulatory and self-healing mechanisms?

3) Have I considered (and done something about) the structure/function interrelationships associated with this person's condition?

4) Have I based my treatment approach on the above three principles?

→

Third, examine any limiting beliefs you may have regarding osteopathic medicine and see if you can debunk them.

Let's revisit the limiting beliefs mentioned earlier and see how quickly they can be eliminated.

1) "I don't have enough time for things like OMT." A true osteopathic physician can always find the time to do OMT, especially if he/she reflects a little on exactly how little time it actually takes a physician to evaluate a patient and determine what the problem is. There is even scientific evidence to support this. Sackett[3] relates the following information: "When Howard Barrows, Geoffrey Norman, Victor Neufeld and John Feightner videotaped random samples of family physicians and internists working up programmed patients with pericarditis, duodenal ulcer, peripheral neuropathy or multiple sclerosis, they documented that the first hypothesis was generated, on average, 28 seconds after hearing the chief complaint (varying from 11 seconds for the multiple sclerosis patient to 55 seconds for the peripheral neuropathy patient). The correct hypotheses... were generated an average of six minutes into these half-hour workups (in less than a minute for the multiple sclerosis patient and less than 90 seconds for the duodenal ulcer patient), and an average of five and one-half hypotheses were generated for each case."

So, a physician needs half a minute to start formulating an hypothesis about what's going on with a given patient, and only six minutes, on average, to come up with the correct diagnosis. In a typical 15 or 20 minute office visit, what could you do with the remaining time? How about some OMT?

2) "There isn't enough scientific evidence to support the value of osteopathic principles." This just simply isn't true. We always had sound research evidence showing the validity of osteopathic principles and the efficacy of uniquely osteopathic methods of treatment. I cite for you the work of Denslow[4], Burns[5], Korr[6], Cole[7], the *Proceedings of the International Symposium*[8] sponsored by the American Academy of Osteopathy and the clinical studies regularly published in the Journal of the American Osteopathic Association, to name just a few examples. There is even more evidence available from Europe and Asia. We need only look in our libraries for as much supportive data as we need.

3) "I can't get paid for it." It is true that there has been a long history of difficulties for osteopathic physicians in getting paid for performing distinctive osteopathic procedures. While I can offer no magic bullet here, there is good news. We have all heard by now that beginning in 1994 the *CPT4 Manual* will contain a new section with separate code numbers for osteopathic manipulation. This may or may not be a cure for the problem, but it should go a long way toward eliminating some of the third party confusion regarding coding and billing for osteopathic manipulative procedures.

We may also think of reimbursement for OMT in another fashion. As we noted earlier, there is always enough time in a typical office visit for OMT. You may or may not get paid in dollars for performing that OMT. But if that satisfied patient, who has just received something from you that he or she cannot get anywhere else, refers five or ten friends and relatives to you, then did you or did you not "get paid" for doing that OMT? Perhaps all you need to do is expand your definition of reimbursement just a little.

4) "I don't feel skilled enough." As we noted earlier, this may be from lack of training in school or from loss of skill due to lack of training during clinical clerkships or postgraduate training. In either case, there is only one answer to this problem: you must retrain yourself in, or increase your mastery of, these vital osteopathic skills. There are any number of ways to do this. There are numerous continuing medical education courses in osteopathic manipulation offered regularly by the American Academy of Osteopathy as well as other

[3] Sackett, op. cit., p. 16.
[4] Northup, GW. Osteopathic Research: Growth and Development. Chicago: American Osteopathic Association, 1987. pp. 15-16.
[5] Ibid, pp. 12-14.
[6] Peterson, B., Ed.,Collected Papers of of I. M. Korr. Colorado Springs: The American Academy of Osteopathy, 1979.
[7] Northup, op. cit., pp. 31-35.
[8] Patterson, MM and Howell, JN, eds., The Central Connection: Somatovisceral/Viscerosomatic Interaction. 1989 International Symposium. Athens, OH: University Classics, Ltd., 1992.

Letters

regularly by the American Academy of Osteopathy as well as other osteopathic institutions. If such courses are not feasible for you, perhaps you could attend lectures or workshops at your local osteopathic hospital or at your state osteopathic association meetings. Perhaps there is a colleague in your community who would be willing to get together with you and help you to enhance your osteopathic manipulative skills. There is always a way to do this if you are committed to it, if it is part of your identity. Again, these are some of the most common limiting beliefs regarding osteopathic medicine expressed to me by my colleagues. You may be able to think of others, and now you know that with a little thought and effort these limiting beliefs can be turned into positive components of one's osteopathic identity.

Finally, be a role model.

Make sure everyone you come into contact with, be they public citizen, osteopathic medical student, intern resident or colleague, can identify you as an osteopathic physician by your actions. Take the final step that will insure for all time your osteopathic identity: make a firm commitment to this identity by broadcasting it to everyone around you. Make use of this identity every day and it will surely become conditioned within yourself. In this way you and everyone else will know that you have truly **"found the pony"!** ❑

Happy Holidays!

To: James A. Keller, DO

Dear Dr. Keller:

Your article, "Osteopathic Medicine" in *The AAO Journal* for Fall 1993 was of such interest to me that I felt I would like to tell you and to thank you for so stressing the importance of OMT.

My husband, Carl M. Cook, practiced over here as an osteopathic physician for almost 50 years -- I wonder if perhaps you knew or met him when he used to go over as often as possible to do post graduate work in his hospital, the Philadelphia College of Osteopathy and to attend AOA Conventions.

Throughout all his professional life he used the wonderful healing powers of OMT and in his London practice he had patients from all over the world. I worked as his secretary and receptionist for 23 years and so had the opportunity to witness the healing effects of this on his patients from all walks and professions, many of whom came, or were sent to him by other doctors, as "wrecks". I do not recall a single case in which he failed to cure or give relief and the possibility of living a normal life to these poor people.

I was myself a "wreck" when I first came to him as a patient almost 40 years ago with a back condition which had never been properly diagnosed. Now at 87 I still have excellent health and am able to do most things, drive, etc. I say this in no spirit of boasting but in deep thankfulness and lasting gratitude for what osteopathy, and in particular OMT, has meant to me.

When my husband's health finally broke, largely due to overwork, he was finally advised to leave England and go to live in a warm dry climate, and we went to live in Arizona. His lasting regret was that he was unable to continue to give the help he knew was in his power. Often he expressed his sadness - and surprise - that a number of osteopathic physicians he heard about were not practicing OMT and had gone into other fields. "If only they could realize the privilege they have - they don't know how lucky they are - they're throwing away their birthright!" he would say sadly to me.

In his last year, during which he suffered intensely, he wrote his autobiography, which so many had asked him for years to do. He completed it just before he died in 1980, and on my return to England I had it printed by the Oxford University Press. So often I have been asked why it wasn't available in bookshops, but the Academy of Osteopathy took many copies and I am happy to know it has reached many of the younger osteopathic physicians and students. I don't know whether you have seen the book, *You Must Become a Doctor*, but you can get a copy from the Academy, of which he became an Honorary Life Member.

I have since founded in it the Carl Moore Cook Memorial Fund with special emphasis on the teaching and furtherance of Osteopathic Manipulative Therapy.

Please forgive this somewhat long letter from a complete stranger and 'lay person', but I owe such an unpayable debt to osteopathy and OMT myself that I felt impelled to write and thank you.

All best wishes, yours sincerely,

Mrs. Rosemary A.B. Cook

England

From the AOBSPOMM Files

AAO Case History

By Robert Paul Lee, DO

Editor's Note: Dr. Lee is a 1976 graduate of Kansas City College of Osteopathic Medicine. He completed his residency in osteopathic manipulative medicine in 1986. Dr. Lee is board certified in OMM and holds a certificate of competency in osteopathy in the cranial field. Dr. Lee is presently in private practice in Durango, Colorado.

An athletic, 60 year-old clinical social worker came to me for a trial of osteopathic manipulative treatment to see if it would help with her mid-back pain and low back pain, which was associated with moderate rotoscoliosis. Eighteen months prior to her first visit with me she had pains in her neck and her legs, as well as in the right deltoid muscle preventing her from moving her arm to do synchronized swimming. Treatment from various practitioners ameliorated these latter complaints, but her mid and low back continued to bother her. Favoring her right knee, which was injured 15 years prior to her first visit with me, seemed to exacerbate the mid and low-back pain. She decided to seek my services upon the recommendation of her colleague, who was a patient at that time. Following the delivery of her last baby, she had been treated with OMT which had resolved her low back pain at the time.

The pain from the scoliosis was frustrating for the patient because she was unable to participate in her synchronized swimming. With the coming of the winter months, she was concerned that she would not be able to do her cross-country skiing. She had always been athletic, participating in acrobatics and competitive diving as a younger woman. But it seemed that in the more recent years, in spite of her athletic endeavors and multiple treatment modalities, she was less and less able to participate in strenuous activities.

Some of the treatments that she had received were rolfing, multiple chiropractic modalities and deep tissue massage. Most recently, prior to her first visit with me, she had been receiving treatment from a particular chiropractor who has a strong reputation. She commented that with his work on her neck, the degree of her scoliosis decreased somewhat. His treatment had relieved her right shoulder pain and mid-back pain but now her low back was hurting so much that it was difficult for her to walk.

A postural X-ray demonstrated her right lower extremity to be four mm. shorter than the left. The sacral base was unlevel, 22 mm. lower on the right than the left. There was mild to moderate multi-curved thoracolumbar scoliosis. From T7 to the sacral base there was a concavity to the left at 17°. From Tl to T6 the spine was concave to the right at 18.5°. The lumbosacral angle is 40° and the center of gravity passed through the middle third of the sacral base. Moderate degenerative joint disease changes of the L1-2 intervertebral disc space was also noted.

Examination of the patient demonstrated a woman who was younger in appearance than her age of 60. She had an obvious scoliosis upon gross examination. She had very good gross spinal motion, as well as gross motion of her extremities. Because of the scoliosis, there was decreased left sidebending in the lumbodorsal spine and right sidebending in the mid and upper thoracic spine.

Palpatory examination revealed that the right knee tended to a varus position, the right fibula being posterior. In the supine position, the sacral base was low on the left with the entire sacrum shifted to the right at its base. The scoliotic curve is manifested with the fourth lumbar vertebra being sidebent right and rotated left. The eighth thoracic vertebra is sidebent left and rotated right and the fourth thoracic vertebra is sidebent right and rotated left. C2 is sidebent right and rotated right. The occipito-atlantal junction is sidebent right and rotated left. The cranium is in a left torsion pattern with occipital compression and frontal compression. The cranial rhythmic impulse is restricted throughout the cranium.

After her first visit with me, on October 15, 1989, she was pain free for one week after a spontaneous articulation occurred while she was twisting in a chair, giving her substantial relief. However, her symptoms slowly reoccurred. She also noticed that her tinnitus was worse with decreased hearing acuity.

At her third visit with me on November 15, 1989, she complained of stiffness but had much less pain. She was sleeping better and now able to get out of bed without difficulty.

She felt that she was able to resume her activities. It was also obvious upon examination that her scoliosis was less prominent, the curves being less severe and the tissues being more supple. I advised her to return to synchronized swimming and begin a course of physical therapy under the guidance of an individual who provides a combination of instruction in exercise and yoga.

The following week, the patient came in complaining of horrible tinnitus and pressure in her face which seemed to subside just prior to her visit with me. But, she felt that her left ear would not pop. I continued to treat her cranium, sacrum, transverse diaphragms, and spine.

On December 13, 1989, she returned stating that her sinuses had opened a lot and that her right shoulder felt much improved. The thoracolumbar pain was intermittent but her right knee was most troublesome. Treatment was directed to the right knee, as well as the cranium, spine and sacrum.

On December 28, 1989, she related that she continued to have stiffness in her low back, but the pain was gone. She was enjoying her swimming again and the tinnitus and facial pressure were reduced. She continued to feel a minor tension into the right deltoid region and into the low back. During the treatment at this session, the long fascial tension from right cuboid to right fibula and knee was given attention as it passed through the quadriceps femoris into the right pelvis at the sacroiliac joint and into the right diaphragm. This fascial tension proceeded on into the occiput. A left lateral strain pattern revealed itself for the first time. Myofascial and craniosacral treatment was employed resulting in good releases.

The focus of her difficulties began to shift to the right knee on visits on February 5, 1990, February 22, 1990, and March 12, 1990. Although the patient strongly resisted, I referred her to an orthopedic surgeon who recommended a meniscectomy. Palpatorily, it was obvious that she did have a ruptured posterior meniscus on the lateral aspect of the right knee. With cross-country skiing and other exercise, the knee had become swollen and quite painful.

She was taken to surgery on March 30, 1990, where arthroscopic meniscectomy was performed with a good result. Debridment of the femoral condyles and patellar cartilage was also performed.

Six weeks following surgery she complained that she was hurting everywhere. She was limping on the right knee. I treated her with the percussion vibrator and encouraged her to resume swimming[1]. By early July, the patient was able to hike eight miles and was swimming her usual routine.

I discharged the patient in July, 1990. Her scoliosis was obviously reduced by palpation and observation in the texture of the tissues and in angulation. She had full range of motion and was able to do her usual athletic endeavors.

This case points up the importance of physical exercise performed by a well motivated patient in conjunction with osteopathic manipulative treatment. This combination raised the level of this patient's well-being and restored her to a functional level that was above that of the average population, with or without scoliosis.

This case also demonstrates the relationships of the cranium and appendicular structures to the condition of scoliosis. Once attention was given to her cranium and knee, her condition stabilized, and she became pain free and functional on a higher level of physical capability. Palpatory findings confirmed the improvement that the patient reported. Although the spine retained the tendencies of the 50 year old scoliosis, it had free motion in all directions throughout. She was able to sleep and exercise normally.

As observed by Arbuckle, spinal scoliosis may be related to preceding obliquity of the head from birth[2]. Frequently, the varus tendency of the knee also originates from intrauterine positioning or the forces of labor. What condition of health this woman could have attained, had she been treated appropriately in her infancy is interesting to speculate.

[1] Fulford, R., personal communication, 1988

[2] Arbuckle, B.E., Scoliosis Capitis, JAOA, Vol. 70, pp. 131-137, October 1970. ❑

Letter to A.T. Still

Dear Doctor Still,

It would not surprise you to know that people both within and outside of the profession still struggle, to this day, about what would constitute a definition of osteopathy. All kinds of things are considered as people try to categorize what it is we do as osteopathic physicians. One of my colleagues concluded some time ago that we really cannot define osteopathy, we can only describe it. That's certainly an interesting viewpoint.

I personally like to look at the old osteopathic literature and find out what people in the old days had to say about these topics. After all, many of these people were taught by you, and they are the closest link we have to your own thoughts other than your own writings.

One of my favorite authors is your student, G. D. Hulett. His book, *Principles of Osteopathy*, was reviewed directly by yourself, so it would seem that what he had to say would reflect your teachings. Hulett went through great pains to establish his definition of osteopathy: "A system of therapeutics which, recognizing that the maintenance and restoration of normal function are alike dependent on a force inherent in protoplasm, and that function perverted beyond the limits of self-adjustment, is dependent on a condition of structure perverted beyond those limits, attempts the reestablishment of normal function by manipulative measures designed to render to the organism such aid as will enable it to overcome or adapt itself to the disturbed structure."

Now that's an interesting definition of osteopathy. What I find even more interesting, however, is that he based his definition on certain assumptions:

1. Cure is the prerogative of the organism.

2. Functional disorders will be self-adjusted except where complicated with or dependent on structural disorders which are beyond the limits of self-adjustment.

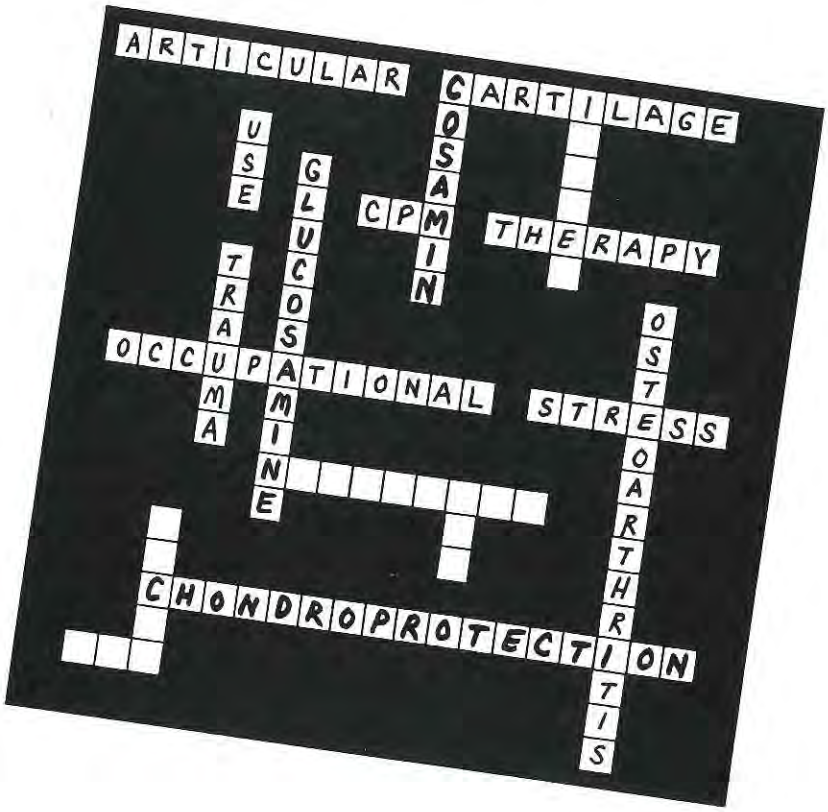
3. Removal of structural disorders constitutes the treatment.

Somehow those three points seem to sum up very nicely what we refer to as osteopathic philosophy, or at least part of it. I especially like the idea that "cure is the prerogative of the organism". This seems to say that no matter what we may do as physicians, we cannot hope that a patient will get well unless we somehow interact with the whole person. Otherwise nothing can be accomplished.

Sometimes when we get bogged down with wondering what osteopathy is all about, it's nice to be able to go back to the writings of you and your students. A little research into this information seems to pay off in a wealth of pure unadulterated truth.

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

Take The Puzzle Out Of Connective Tissue Problems...



A myriad of joint and spinal conditions are associated with articular cartilage and disc deterioration. Several factors can lead to the deterioration, such as direct injury to the joint, mechanical stress due to overuse of the joints, aging and/or hereditary conditions.

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A Description of the Common Compensatory Pattern in Relationship to the Osteopathic Postural Examination

by Guy A. DeFeo, DO and Laurence V. Hicks, DC

About the Authors:
Dr. DeFeo is a 1988 graduate of the University of New England College of Osteopathic Medicine (UNECOM). He is certified in Osteopathic Manipulative Medicine (OMM) and currently holds a faculty appointment at UNECOM in both the General Practice and Osteopathic Principles and Practice Departments.

Dr. Hicks graduated from the Western States Chiropractic College in 1984. He is currently a fourth year medical student at UNECOM. Dr. Hicks is a National Health Service Corps Scholar and intends to pursue postgraduate training in internal and family medicine.

Introduction

Postural evaluation is an integral part of a comprehensive musculoskeletal work-up. Many methods have been developed to assist the physician with this most fundamental task. A number of decades ago a device which used plumb and level lines was developed to assess anatomical asymmetry in the standing patient. More recently, the use of bilateral scales has been employed by certain practitioners to determine load-bearing imbalances side-to-side and front-to-back. Very recently, sophisticated computer software programs have been developed and applied to the previously mentioned diagnostic designs to make it possible for the examiner to objectify multiple parameters related to the postural examination.

The upright postural evaluation methodology common to the clinical disciplines of osteopathy, chiropractic and allopathy is inherently limited. One, it requires the patient to assume an erect weightbearing position. For many patients this position would be difficult or even impossible. Two, for the minimal amount of information obtained, it is time consuming. Three, modern analytic equipment can be expensive. Four, it does not conclude with sufficient information necessary to allow the practitioner to correct existing articular lesions.

Early on, the osteopathic profession saw the need for an inexpensive, reproducible and expedient method to assess postural imbalances and related somatic dysfunction. The system which has been developed provides decided advantages. It does not require the patient to be upright or weight bearing. It is quick. It requires no extraneous equipment. Once the evaluation has concluded, the clinician has adequate information about postural imbalance and somatic dysfunction so as to apply manual manipulative techniques in a corrective manner.

Certain osteopathic physicians have observed clinically that a significant percentage of the population assumes a consistently predictable postural adaptation, arising from nonspecific mechanical forces such as gravity, gross and micro-trauma, and other physiological stressors in the external milieu. These forces have their greatest impact on the articular facets in the transitional areas of the vertebral column. Citations in the osteopathic literature refer to this postural adaptation as "the common compensatory pattern" (CCP). The CCP has been the subject of the writings of Zink, 1979; Johnson, 1988; Ellestad et al, 1989; Johnson and Cross, 1990 and Cross and Johnson, 1990.

In the CCP, an examiner will note the following observations will apply to the supine patient. The left leg will appear longer than the right. The left iliac crest will appear higher or more cephalad than the right. The pelvis will roll passively easier to the right

than to the left because the lumbar spine is sidebent left and rotated right. The inferior thorax is deviated to the left and the thoracic spine is sidebent right. The sternum is displaced to the left as it courses inferiorly. The left infraclavicular parasternal area is more prominent anteriorly because the thoracic inlet is sidebent right and rotated right. The upper neck rotates easier to the left. The right arm appears longer than the left when fully extended. While the CCP will be observed most often during examination, we will also note that variations do occur from patient to patient. These variations from the CCP were referred to by Zink as disparent patterns.

While postural examination techniques in the supine position appear to be fully appreciated within the osteopathic profession, the concept of the CCP may still be largely under recognized. This paper represents a further attempt to describe the CCP in relationship with the osteopathic postural examination.

Observation of the Common Compensatory Pattern During the Osteopathic Postural Evaluation

The focus of this paper is to demonstrate the CCP while utilizing the osteopathic postural examination as a diagnostic procedure upon which diversified manipulative techniques could be readily applied. Therapeutic manual techniques will not be demonstrated in this article. Various and sundry manipulations will be readily inferred by experienced clinicians as they read the general listings.

The examination procedure is undertaken with the patient supine.

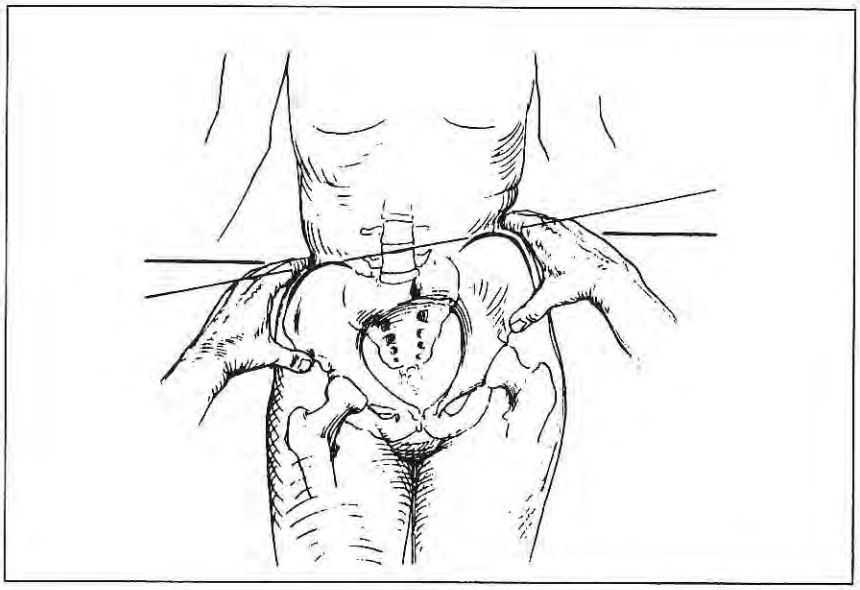

Fig. 1

The patient should be comfortable and modestly draped. The physician should make proper use of the dominant hand and eye so as to arrive at an accurate diagnosis. The examiner begins by comparing the length of the legs bilaterally. S/he should stand at the foot of the table facing the patient. In the CCP the left leg will appear to be longer as compared to the right.

Next, the examiner compares the height of the innominates by moving to the side of the table and placing the lateral aspects of his/her hands immediately over the prominence of the crests. Slight medial pressure may be required in the obese patient to adequately visualize these landmarks. In the CCP the left crest is more cephalad than the right due to the left sidebending of the lumbar spine (**Fig. 1**).

At the same time the doctor should hook his/her thumbs just under the anterior superior iliac spies (ASIS) to assess variation bilaterally (**Fig. 1**). If the patient is in the CCP, the ASIS on the left should appear relatively superior. This information suggests that the left innominate is rotated posteriorly and inferiorly if we were using the posterior superior iliac spine (PSIS) as a reference.

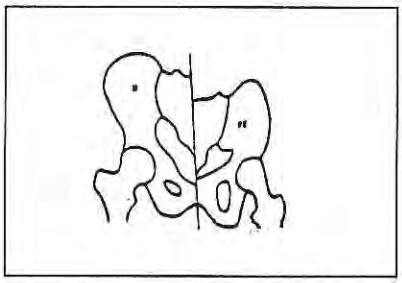

Fig. 2

(**Fig. 2**) schematically demonstrates how the left innominate would appear radiographically as compared to a neutral posture.

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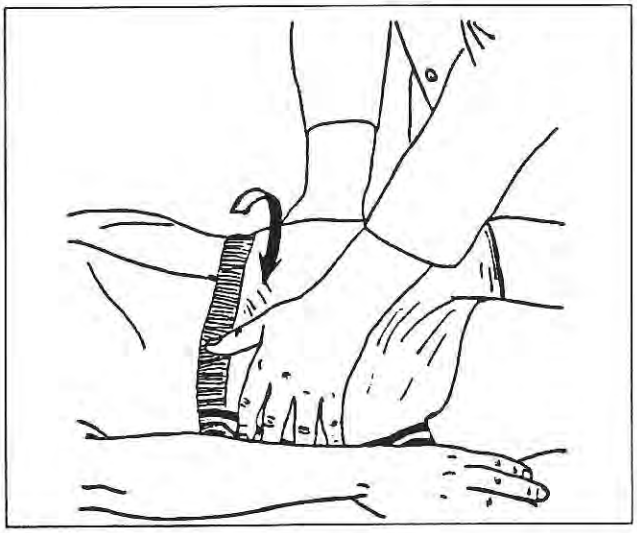


Fig. 3

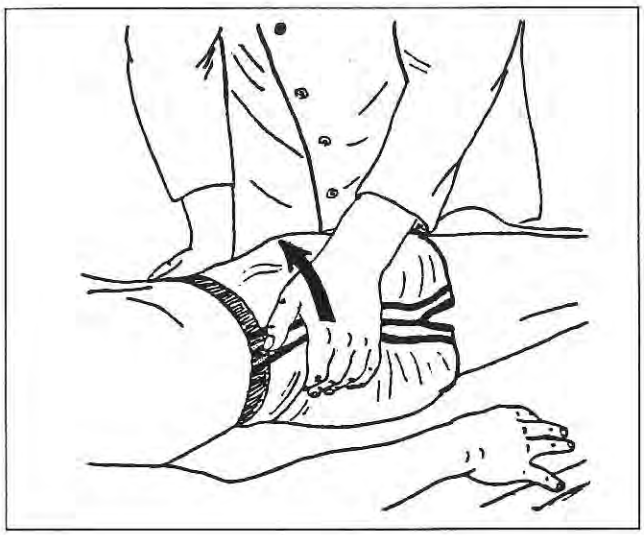


Fig. 4

At this point the physician should attempt to rotate the pelvis of the patient, rocking first to the right and then to the left (**Fig. 3 & 4**). The side to which the pelvis rocks with the least resistance suggests the general rotation of the motion segments between the lower lumbars and the sacrum.

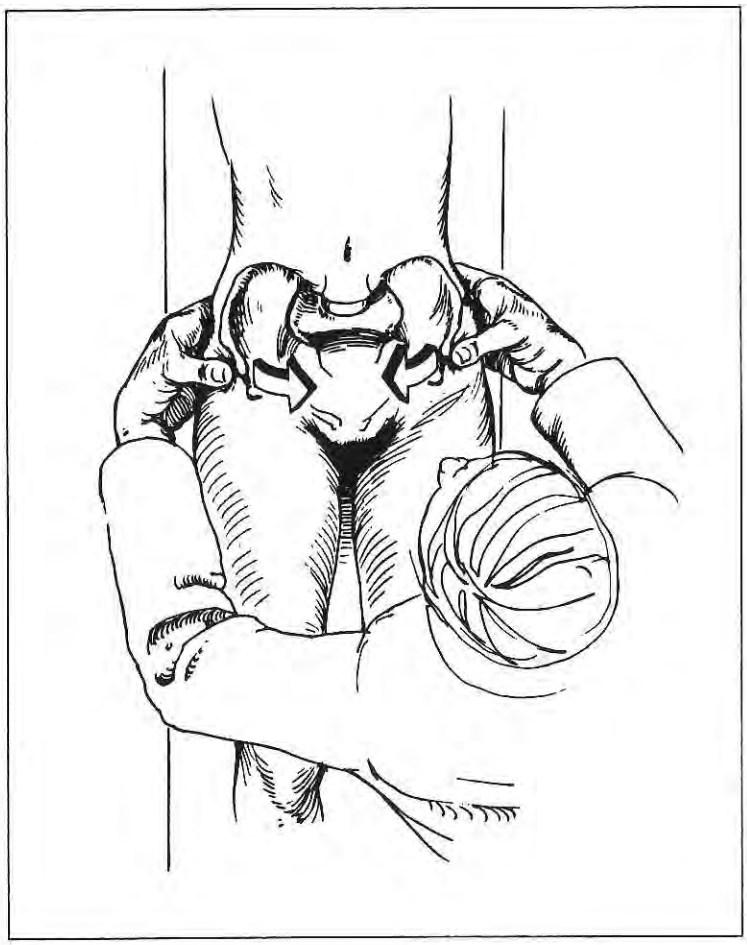


Fig. 5

The physician should also palpate the lumbar paravertebral musculature for tautness and tenderness. In the CCP the pelvis wlll more readily rotate to the right and the left paraspinal soft tissues will appear more contracted and perhaps more tender to palpation (**Fig. 5**).

These findings and the relative elevation of the left crest noted earlier indicates that the lumbars are in a right rotary malposition and the sacrum is malpositioned such that there is a left rotation on the left oblique axis (**Fig. 6**).

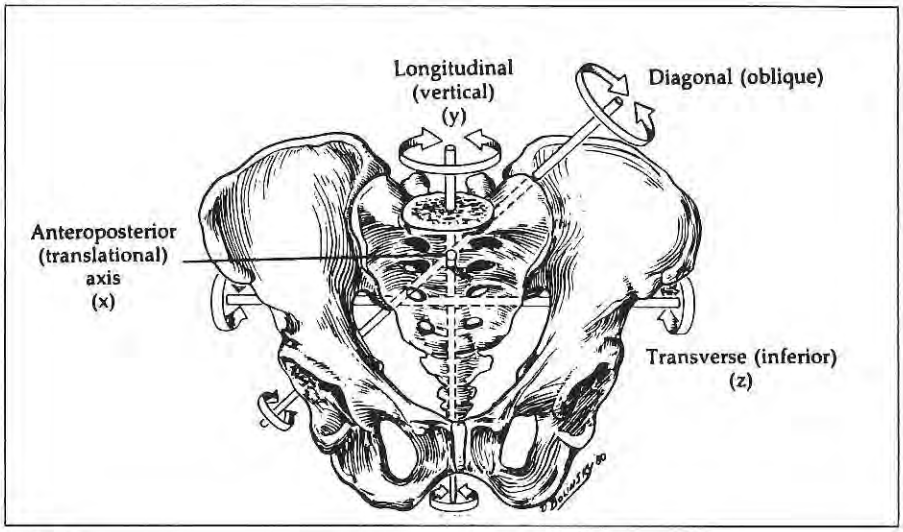
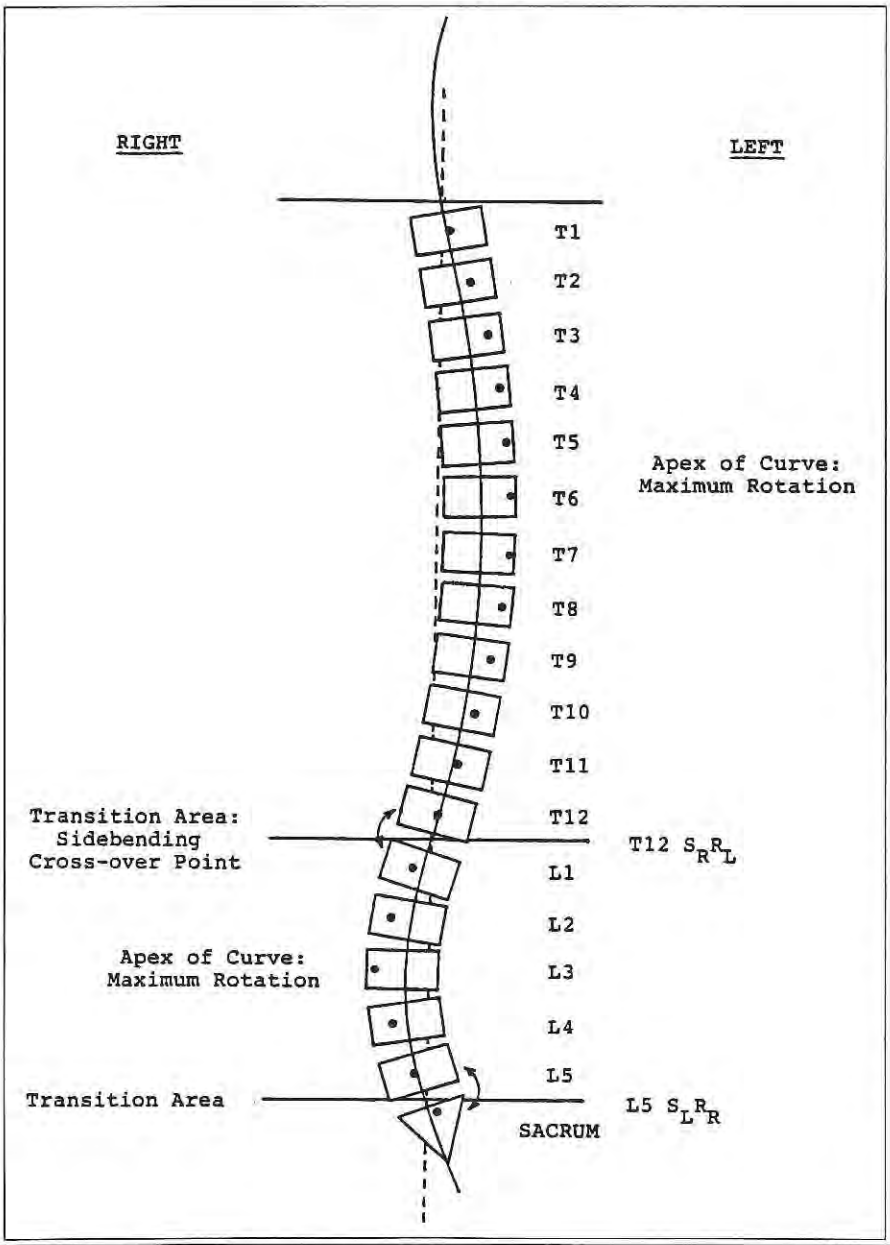


Fig. 6



The sacral base is tilted to the right (**Fig. 7**). Secondarily, we may also conclude that the lumbar spine is sidebending to the left, forming a mild dextroscoliotic curve apexing at approximately L3.

Upon visualization and palpation, the lower thoracic cage will appear to rotate or deviate to the left and the thoracic spine will gradually sidebend to the right, forming a mild levoscoliotic curve, in CCP, as it compensates for the lumbar and pelvic somatic adaptations. These changes suggest that the thoracolumbar transitional area is rotated left (**Fig. 7**) and sidebent right.

→

Fig. 7

Now the physician should palpate the infraclavicular parasternal area with the pads of his/her fingertips **(Fig. 8)**. In CCP the left infraclavicular parasternal area is more prominent or convex and resists manual pressure to a greater degree than its contralateral side. It may also be more tender to touch.

The articulation of the first rib with the sternum is a synchondrosis and, as such, it reflects rotation in the first thoracic vertebra (T1). In CCP, T1 is rotated right and this forces the left infraclavicular parasternal region to be more prominent on the left side.

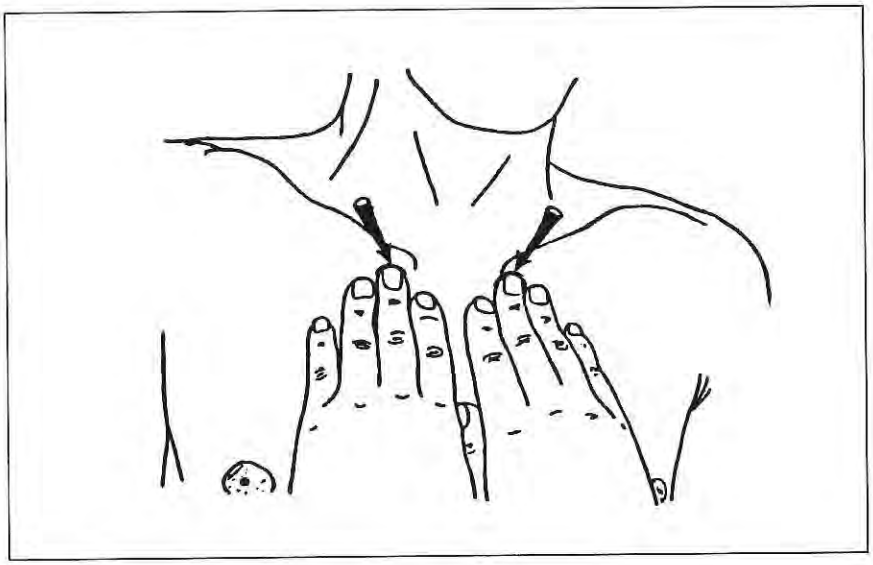


Fig. 8

At this point the examiner moves to the head of the table and applies gentle pressure in an inferior direction with his/her thumbs, so as to depress the transverse processes (TP) of T1 and the adjoining first ribs **(Fig. 9)**. In CCP the left TP is more superior than the right and resists the operator's downward forces, suggesting a right sidebending of T1.

If treatment were to be undertaken at this point, with the aforementioned data, two separate maneuvers would be required. T1 would have to be rotated left with one procedure and also sidebent back to neutral with a compensatory left lateral flexion secondary procedure.

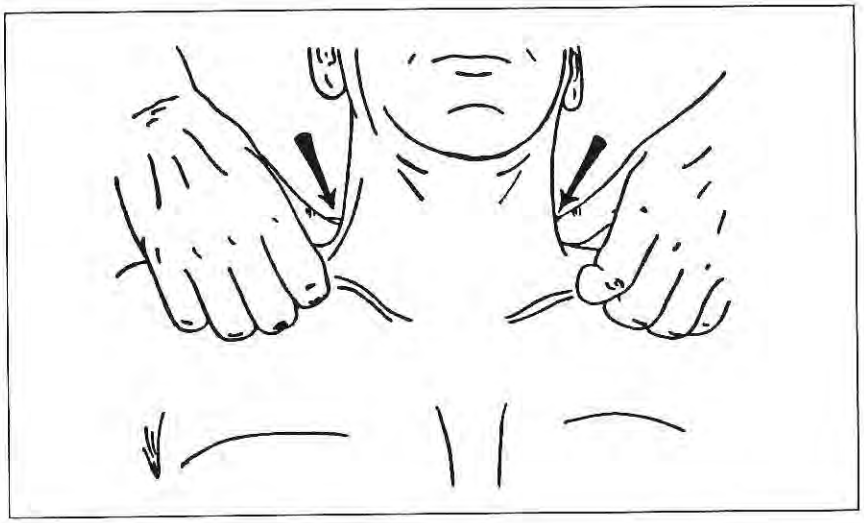


Fig. 9

In CCP the neck is sidebent left, creating a mild left-sided concavity or dextroscoliotic curve. The examiner should rotate the neck to the right and left **(Fig. 10)**.

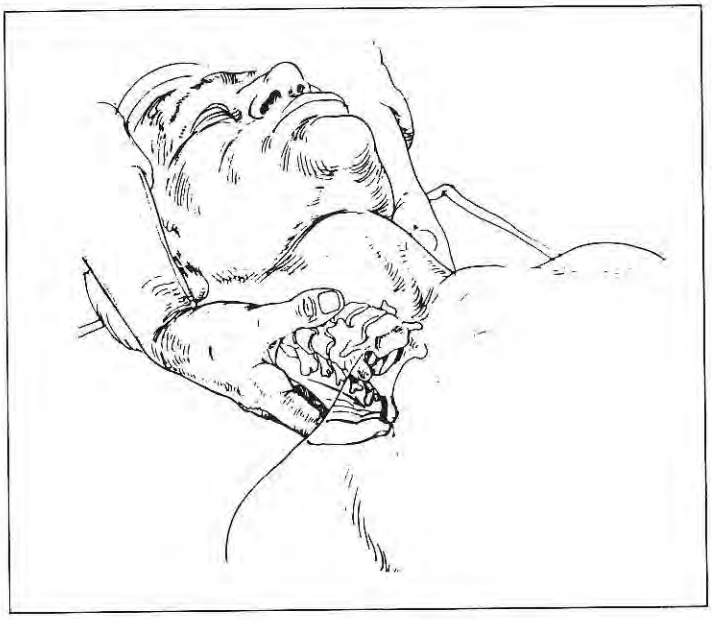


Fig. 10

In CCP the upper cervical complex should rotate more easily to the left, suggesting that the upper cervical segments are malpositioned in left rotation **(Fig. 11).** The upper cervicals should also sidebend easier to the right, suggestive of a right lateral flexion malposition.

Next, the examining physician should extend the arms upward over the head of the patient. In CCP the right arm will appear longer, reflecting the torsional stresses of the thoracic cage and inequality of eccentric shoulder girdle muscular contraction.

A general idea of the lumbar lordotic curve can be obtained sliding the flat of the hand under the back of the supine patient. It will not appear as prominent as it would if the patient were standing upright with his/her back to a wall, but with practice the physician will get a "feel" for the normal lordotic supine presentation **(Fig. 12).**

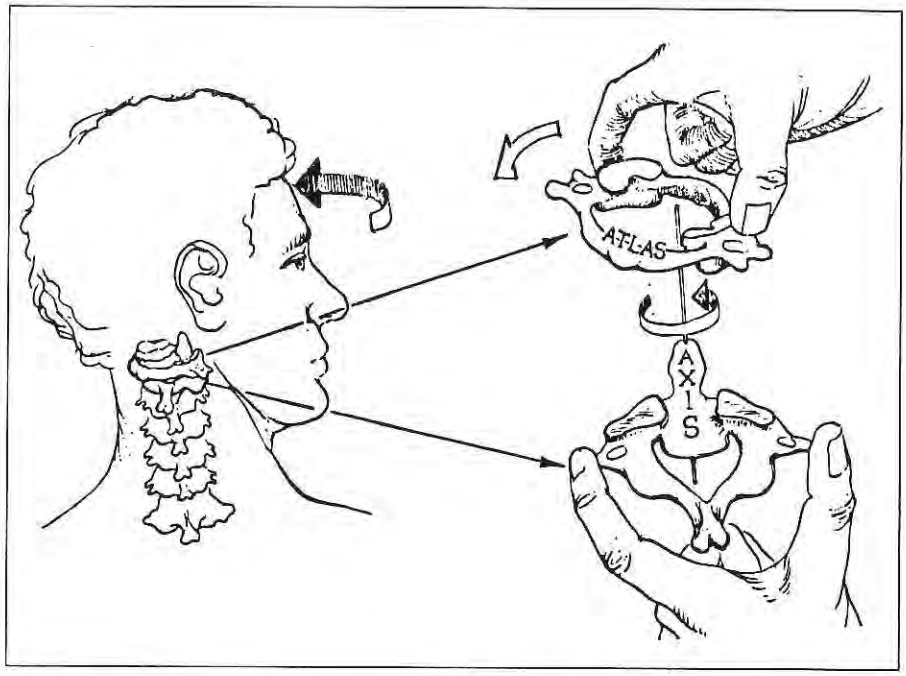


Fig. 11

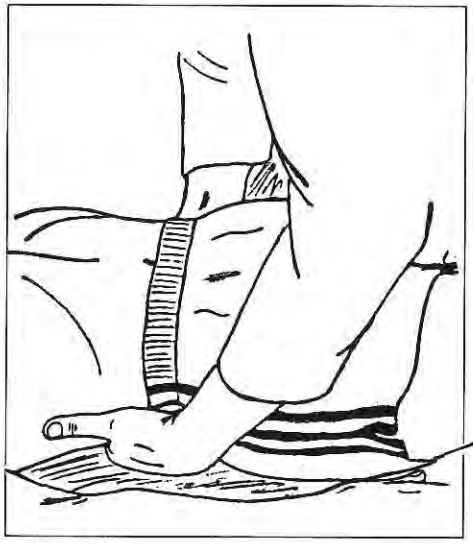


Fig. 12

Conclusion

This paper has conveyed information, developed within the osteopathic profession, regarding the recumbent postural exam. The common compensatory pattern was described and it was used as a working model so as to enhance the description of the supine postural exam. Therefore, utilization of a recumbent postural exam as part of the total structural exam gives the examiner a rapid diagnosis leading to appropriate utilization of osteopathic manipulative therapy. One should bear in mind that while we most often find the CCP during the supine postural examination, other configurations may also be observed and as always the total clinical presentation should be evaluated. Alternate configurations have been referred to by Zink as disparent patterns. ❑

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Message from the UAAO Chair

OSTEOPATHIC EDUCATION:

Out of the Classroom & Into the Clinics

Anita W. Eisenhart
PCOM '94

The Undergraduate American Academy of Osteopathy (UAAO) is a vibrant group of student doctors eager to learn the practices and principles of osteopathic medicine. We are *osteopathic sponges* in the presence of modern osteopathic greats such as Drs. Larry Jones, Michael Kuchera, Herbert Yates, Stephen Blood, Anthony Chila, Viola Frymann and scores more!

The UAAO Council has chosen this year's theme to be **Out of the Classroom and Into the Clinics.** Certain standards for Osteopathic Principles and Practices (OP & P) are established for the early didactic years of medical school. Every osteopathic medical student spends a predetermined number of hours in the osteopathic lecture hall and in hands-on teaching sessions during the first two years of medical school. Heaven only knows what happens to us in the hospitals, clinics and offices!

Many students experience the ever-unpopular statement, "I don't have time for manipulation in my practice." This is NOT setting a good example for curious and confused medical students! We see OMT orders written by residents and interns in the hospital that are rarely, if ever, followed. Where is the *Osteopathic Difference?*

Fortunately, there is hope for our profession. Many hospitals have excellent osteopathic teaching sessions and there *still* are some osteopathic DOs out there. The federal government has recently grown more interested in our profession. And there are many UAAO students who are continuously questioning and (hopefully) influencing the allopathic generation of DOs before us to incorporate the teachings of A.T. Still into their practices.

Many patients on service receive OMT at my suggestion or initiative. When the attending physician sees my note in the chart, he/she is generally grateful and encourages continued treatment as indicated. And, thus, a student has influenced an attending physician without stepping on fragile toes. Simple!

I consider educating my colleagues and the public to become more *osteopathically aware* an integral component of being an osteopathic medical student. For example, a student attending an osteopathic medical school recently told me that he will be going into Ear, Nose and Throat as a profession because he is not interested in using OMT. I politely corrected his weak fund of knowledge and listed several clinical indications for an ENT specialist to put his/her hands on the patient.

I realize I am preaching to the folks who are actually in church (or synagogue as it were). But you, as Academy physicians, can influence your colleagues in the same way I do (perhaps with a bit more credence). You can influence your alma mater via the alumni association (you know what is said about money talking).

UAAO students are very concerned about the future of our profession and are very excited about becoming a part of it. We want to touch, prevent, diagnose, heal and make our patients more comfortable. We want to be osteopathic obstetricians, osteopathic surgeons, osteopathic generalists and the like.

There is a great deal of pride among osteopathic medical students. We have special skills that will elevate us to the title **Osteopathic Physician.** Our gratitude lies not only with Dr. A. T. Still, but with you, the members of the American Academy of osteopathy, that are committed to **Osteopathic Education.**❑

From the Archives

Definitions of Osteopathy as a School of Medicine

from *An Analysis of the Osteopathic Lesion*
George Malcolm McCole, DO, 1935

A

"Osteopathy is a complete system of therapy based on two fundamentals; (1) the normal, living body creates its own remedies against infections and other toxic agents; (2) the body is a vital machine, and correct adjustment is necessary if these remedies are to be created and applied where needed. Osteopathic physicians recognize the effects of strain, injury, wrong posture, overwork, worry, dietary errors, poisons, --also heredity, age, sex, climate, etc., upon health. They take into consideration hygiene and sanitation and take advantage of careful nursing procedures. Osteopathic diagnosis comprises physical examination of the entire body--skeletal, somatic and visceral, nervous and glandular, its distinguishing feature being an intensive search for and study of the osteopathic lesion. Physical findings, chemical, x-ray and other laboratory procedures have a definite place in osteopathic diagnosis. Osteopathy includes the treatment of diseases of women and children, of the eye, ear, nose, throat and other special parts of the body. From its inception, obstetrics and surgery have been parts of osteopathy." -- Ray G. Hulburt.

The above is a rather long statement that we clearly distinguish the definition of osteopathy as a practice from the definition of what we term the "osteopathic concept", and also from the definition of the osteopathic lesion. The definition is valuable in that it gives recognition to the fact that the practitioner of osteopathy is a *physician.*

When possible, the term "physician" should be used with the term "osteopathic" when the licensed practitioner of osteopathic therapeutics is to be designated, for he is legally a *physician* and a practitioner of the healing art of *medicine* or *physic.*

B

"Osteopathy is the practice of the healing art in all branches with its therapeutics majoring in manipulation."

C

"Osteopathy is the practice of the healing art in all branches with its therapeutics majoring in manipulation and as taught in colleges recognized by the American Osteopathic Association."

This definition of osteopathy as a practice of the healing art is considered a good definition for legislative and publicity purposes, for it is short, easily grasped at a glance and is full of meaning. The definition is distinctively osteopathic but does not limit methods of practice. Its chief weakness as a legal definition is that neither the word "medicine" nor the word "physician" appears in it.

D

"The word *Osteopathy*, as used in this Act, is the name of that system of the healing art or school of medicine which in its theory places chief emphasis upon the structural integrity and the natural immunity of the body as health factors, and in its practice places chief emphasis upon the adjustment of structural irregularities and the normalization of functional activity through manipulation."

The above definition calls attention to osteopathy as a school of medicine and is another valuable definition for legislative purposes. It is osteopathic, recognizing as it does structural integrity, natural immunity and functional activity. The definition recognizes both theory and practice and the importance of adjustment in structure and in function.

E

The American Illustrated Medical Dictionary -- Dorland, Sixteenth Edition, 1932 -- says: "The official definition of osteopathy adopted by the American Osteopathic

→

Association is "That system of the healing art which places the chief emphasis on the structural integrity of the body mechanism, as being the most important single factor to maintain the well-being of the organism in health and disease."

F

That the practice of osteopathy is the practice of medicine is attested by *Webster's New International Dictionary* in the following definition: "Medicine. The science and art dealing with the prevention, cure, or alleviation of disease; in a narrower sense, that part of the science and art of restoring and preserving health which is the province of the physician as distinguished from the surgeon and obstetrician."

To carry through the thought that the practice of osteopathy is the practice of medicine, other definitions are presented. Note that the first definition of medicine presented has been taken from a dictionary published in 1874, the year in which A.T. Still announced his discovery of osteopathy.

G

Medicine --"A science, the object of which is the cure of disease and preservation of health. Occasionally it is used to comprehend all the branches of the healing art; at other to comprise one great division, in contradistinction to surgery and obstetrics."--*Dunglison's Medical Dictionary*, Pub. 1874.

H

Medicine --"The art and science of healing, alleviating, or preventing disease by any known means, or the substance or preparation so used. Christian Science; Osteopathy; The practice of medicine; Allopathy."--*Lippincott's New Medical Dictionary*, Pub. 1910., Edited by Henry W. Cattel, AM, MD Fellow College of Physicians, Philadelphia.

I

Medicine --"The science and art dealing with the prevention, cure or alleviation of disease; in a narrower sense, that part of the science and art of restoring and preserving health which is the province of the physician as distinguished from the surgeon and obstetrician."--*Webster's New International Dictionary*, Editions of 1915 and 1934.

J

Physician -- One skilled in the art of physic or the art of healing.

K

Physic --The art of healing diseases; the science of therapeutics.

L

Therapeutics --That part of medical science which treats of the discovery and application of remedies for diseases.

M

"The terms 'osteopathic medicine' and 'osteopathic school of medicine' should not be used when addressing the public. The osteopathic school of the healing arts is scientifically and legally a school of medicine. The public, however, associates the word 'medicine' with the act of drugging. The Doctor of Osteopathy in his work as family physician, meeting as he does surgery, obstetrics and disease of every nature and recognizing the necessity for personal and community hygiene, cannot be strictly a drugless physician. However, osteopathy's great contribution to humankind is the study of natural immunity and the promoting of that immunity through rational living and body adjustment. The osteopathic profession must stand as a distinct scientific organization before the world. It can maintain that distinction if it concentrates its energies on body adjustment and natural immunity."--Perrin T. Wilson ❑

Michael Patterson, PhD Named Director of Basic Science Research & Professor of OPP at UHS-COM

Michael M. Patterson, PhD has been appointed director of basic science research and professor of osteopathic principles and practice at The University of Health Sciences College of Osteopathic Medicine. He began duties July 12, conducting OPP lectures and labs as well as overseeing research studies in basic science areas.

Prior to joining UHS he was professor of osteopathic medicine and director of research affairs at the Ohio University College of Osteopathic Medicine for 16 years. Prior to that, he taught physiology at the Kirksville College of Osteopathic Medicine for six years.

He is active in a number of professional associations and is often invited to lecture at professional gatherings both in the United States and Europe.

His work is widely published and he is on the editorial staffs of several scholarly journals, including being one of the two contributing editors of the *Journal of the American Osteopathic Association.*

He has been responsible for many research studies funded by the American Osteopathic Association and other granting foundations for more than 30 years. His primary research interest is in spinal cord function. ❑

OMT Update (Intermediate Course)

"Application of Osteopathic Concepts in Clinical Medicine and Preparation for OMM Boards"

Program Chairperson: Melicien Tettambel, DO, FAAO, Certified AOBSPOMM, Certified AOBOGS

Program

Saturday, February 12

8:00- 8:20 am	*Introduction & Course Overview* Melicien Tettambel, DO
8:20- 9:00 am	*High Velocity, Low Amplitude, with Questions and Answers* John Hohner, DO
9:00- 9:40 am	*Muscle Energy* Mark Cantieri, DO
9:40- 9:50 am	Small Group Discussion
9:50-10:30 am	*Myofascial Release* Melicien Tettambel, DO
10:30-11:10 am	*Counterstrain* Mark Cantieri, DO
11:10-11:50 am	*Cranial Osteopathy* Ann Habenicht, DO
12:00- 1:00 pm	Lunch
1:00- 3:00 pm	*Cervical-Suboccipital Troubleshooting (with Case Histories & Treatment Modalities)* John Hohner, DO
3:00- 5:00 pm	*Thoracic Spine* Ann Habenicht, DO
5:00- 6:00 pm	*OMM Board Applications & Case Studies* Faculty

Sunday, February 13

8:00-10:00 am	*The Extremities with Skill Session* Ann Habenicht, DO
10:00-12:00 n	*Lumbar Spine and Pelvis* Mark Cantieri, DO
12:00- 1:00 pm	Lunch
1:00- 2:00 pm	*Selecting a Treatment Modality* Melicien Tettambel, DO
2:00- 3:00 pm	*Dosage of OMT* John Hohner, DO
3:00- 4:00 pm	*Written Exam Prep: "What to Expect"* Faculty
4:00- 5:00 pm	*Oral Prep* Faculty
5:00- 6:00 pm	*Questions & Answers Individual Troubleshooting* Faculty

Faculty:

Mark Cantieri, DO
Certified AOBSPOMM
Ann Habenicht, DO
Certified AOBSPOMM, Certified General Practice
John Hohner, DO
Certified AOBSPOMM, Certified General Practice

Who May Attend:

Educational objectives for AAO are to provide programs aimed to improve understanding of philosophy and diagnostic and manipulative skills of osteopathic physicians and foreign DOs with a full license or a registration, medical, podiatric and dental professions within their licensed privileges of practice and for those in programs leading to such license.

Course Objective:

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

- OMT Review: Hands-on experience and troubleshooting
- Integration of OMT in treatment of various cases
- Preparation for OMT practical portions of certifying boards
- Preparation for AOBSPOMM (American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine)

REFUND POLICY:

All cancellations must be received in writing at least two weeks prior to the opening day of the educational program. An administrative fee of 15 percent of the total registration fee will be charged for all cancellations made prior to the cut-off date established above. No-shows and cancellations received after the cut-off day established above will receive no refund.

Conference Registration

OMT UPDATE & Board Prep Course
February 12 -13, 1994
Embassy Suites Downtown
Indianapolis, Indiana

Name for Badge (please print clearly)

Specialty

Current Certification / Fellowship

City State

AOA Number

College and Year Graduated

SEMINAR FEE:

Prior to January 15, 1994:	
AAO Member	$435
Intern/Resident	$150
AAO Non-Member	$485
After January 15, 1994	
AAO Member	$535
Intern/Resident	$200
AAO Non-Member	$585

Make check payable to the AAO or
AAO Accepts MasterCard and VISA

CME Hours:
2 Days - 18 Category 1-A

Appropriate Dress:
Loose fitting sports attire

Deadline for Advance Registration:
January 15, 1994

Refreshment Breaks/Lunch
Coffee, snacks and lunch will be provided; breakfast buffet compliments of Embassy Suites

OMT Update
Headquarters Hotel
Embassy Suites Downtown
110 West Washington Street
Indianapolis, Indiana 46204
(317) 236-1806

Each suite offers a private bedroom with a choice of either (2) double beds or one king size bed. Each suite also has a sofa bed in the living room. The galley kitchen features a refrigerator, wet bar, coffee maker and microwave. All suites include two televisions, two telephones, an iron and ironing board. Children under 12 stay free in same suite as parents.

Your room rate includes a complimentary American buffet breakfast and a reception each day, movie channels, morning newspaper, indoor pool, whirlpool, sauna and fitness center with aerobic and weight training equipment. Garage parking is $5.00 per day.

Location: Exit Illinois Street north from I-70. Seven miles from Indianapolis International Airport. Call Indy Connection for airport limousine service 241-7100 ($7 one way).

Local Attractions: Adjacent to the Indiana Repertory Theatre, one block from the state capitol, two blocks from the Circle Theatre, Hoosier Dome and PanAm Plaza, three blocks from Union Station and South Meridian Street night clubs, five blocks from Eiteljorg Museum and City Market and six blocks from Market Square Arena.

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Meeting Host:
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Classifieds

DO Wanted!

DO wanted to experience rural health care in remote mountains of West Virginia. Beautifully forested community of Man, 80 miles from state capital in Charleston. Family practitioner needed to provide primary care services to catchment of 30,000 people. Multi-specialty group or hospital-employed practice. Salary $80,000 to $100,000 with paid personal/professional insurances and other major benefits. Work with friendly people who have APPRECIATION FOR YOUR WORK and need your help. Send CV to or call: Greg Davis, Appalachian Regional Healthcare, P.O. Box 8086, Lexington, KY 40533 1-800-888-7045 or (606) 281-2537 collect.

Southeastern Mass

PAIN TREATMENT CENTER is seeking a qualified Osteopathic physician to take over the busy and lucrative OMT practice. Excellent working conditions and virtually no call. Contact: William E. Dworet, DO (508) 994-8493.

DO Needed!

Opportunity available for a Family practitioner to be part of a busy practice at the River Valley Clinic in Northfield, MN. Must be willing to do OMT. River Valley Clinics are owned by Health One in Minneapolis. Contact: David Flicek, Administrator, 1400 Jefferson Road, Northfield, MN 55057, (507) 645-2095.

Books, Skeletons and Skulls Needed

We are pre-doctoral anatomy and OP&P fellows at UNE-COM and plan to practice family medicine emphasizing manipulation. We are interested in acquiring osteopathic books, skeletons and skulls. Please call or write Gretchen Sibley and Ralph Thieme, OP&P Department, UNECOM, Biddeford, ME 04005; (207) 283-0171 ext 533.

Psychiatric Residency Seeks AAO Help in Curriculum Development

Brian T. Fulton, DO, Site Training Director for the UOMHS/Cherokee MHI Psychiatric Residence Training Program, has asked AAO members for assistance in development of osteopathic curriculum for the required course on Psychiatric Principles. He asks for your ideas in expanding the understanding of each of these four concepts as they apply to the practice of psychiatry:

1) Osteopathic manipulative treatment
2) Holism
3) Intrinsic health
4) Attitude within the doctor/patient relationship

You can contact Dr. Fulton or his associate Dr. Erle Fitz at:

Cherokee Mental Health Institute
1200 West Cedar Street
Cherokee, IA 51012
(712) 225-2594

Advance Percussion Vibrator Course

May 21-22, 1994

CME Hours
13 Category 1-A
$350 Registration Fee

The AAO
Headquarters Building
The Pyramids
at College Park
Indianapolis, Indiana

Call (317) 879-1881
for more information

FOR SALE

French Osteopath Jean-Pierre Barral's Visceral Manipulation VHS Videotape Cassettes Available

WVSOM, OMT Dept. offers a complete set of Dr. Barral's video cassettes on Visceral Manipulation. This is the first Course taught in English and the only video cassettes of his available. Each set contains (4) two-hour cassettes. Cost for complete set is $320 plus $5 shipping and handling.

Contact:
WVSOM, OMT Dept.
400 N. Lee Street,
Lewisburg, WV 24901.

Calendar of Events

JANUARY

15-22
Cruise/ Basic ODT Program
American Academy of Osteopathy
Eastern Caribbean
CME Hours: 20 (Category 1-A)
Contact:Diana Finley
Associate Executive Director
(317) 879-1881

27-30
Fifth Annual Osteopathic Winter Seminar
Holiday Inn Surfside
Clearwater Beach, FL
Hours: 28 Category 1-A
Contact: PCOMS
(813) 399-9299

FEBRUARY

4-6
AAO Education Committee
Headquarters Building
Indianapolis, IN
Contact: Stephen J. Noone, CAE
Executive Director
(317) 879-1881

12-13
OMT Update/Board Prep Course
American Academy of Osteopathy
Embassy Suites Downtown
Indianapolis, IN
CME: 22 Hours (Category 1-A)
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

19-20
AAO Long Range Planning Committee
Headquarters Building
Indianapolis, IN
Contact: Stephen J. Noone, CAE
Executive Director
(317) 879-1881

27- March 4
Ski and CME Midwinter Conference
Colorado Society of Osteo. Medicine
Keystone Lodge & Resort
Keystone, CO
Hours: 38 Category 1-A
Contact: Patricia Morales, CSOM
(303) 322-1752

MARCH

3-6
91st Annual Convention
Florida Osteopathic Medical Assn
Doral Ocean Beach Resort
Miami Beach, FL
Hours: 30 Category 1-A
(includes 5 Risk Management and 3 AIDS)
Contact: FOMA
2007 Apalachee Parkway
Tallahassee, FL 32301
(904) 878-7364

18-20
Introduction to Visceral Manipulation
Guest Speaker:
Jean-Pierre Barral, DO, MROF
The Broadmoor Hotel
Colorado Springs, CO
Hours: 18 Category 1-A
Contact: Diana Finley
Associate Executive Director
(317)879-1881

21
Intermediate Visceral Manipulation
Guest Speaker:
Jean-Pierre Barral, DO, MROF
The Broadmoor Hotel
Colorado Springs, CO
Hours: 7 Category 1-A
Contact: Diana Finley
Associate Executive Director
(317)879-1881

23-26
Annual Convocation
American Academy of Osteopathy
The Broadmoor Hotel
Colorado Springs, CO
Hours: 29 Category 1-A
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

APRIL

21-24
94th Annual Convention
Oklahoma Osteopathic Assn
Shangri-La Resort
Afton, OK
Contact: OOA
(405) 528-6102

MAY

21-22
Advance Percussion Vibrator Course
American Academy of Osteopathy
AAO Headquarters Building
Indianapolis, IN
Hours: 13 Category 1-A
Contact: Diana Finley
Associate Executive Director
(317) 879-1881

JUNE

18-22
Basic Course in Osteopathy in the Cranial Field
The Cranial Academy
Oklahoma City Marriott
Hours: 40 Category 1-A anticipated
Contact: Patricia Crampton
Executive Director
(317) 879-9713

23-26
Explorations in Osteopathy
The Cranial Academy
Oklahoma City Marriott
Hours: 20 Category 1-A anticipated
Contact: Patricia Crampton
Executive Director
(317) 879-9713

Special Videocassette Offer for 1993 Convention in Boston

The Academy is pleased to make this promotional offer of videocassettes from its 1993 Convention. The offer is being made to Convention registrants, colleges of osteopathic medicine and interested health care providers.

Order by February 1, 1994 to get this special package price -- $99.95 for the complete set plus $10.00 for postage and handling. Copies of individual tapes are $35.00 each plus $5.00 postage and handling. Tape #4 includes handouts from the lecture and sells for $29.95 plus $5.00 postage and handling.

Tape # 1 *Welcome*
Walter C. Ehrenfeuchter, DO, FAAO, Program Chairperson

How to Fix Feet -- Form, Function and Foul-ups
Edward J. Faherty, Jr., BCP

Horseback Riding Therapy
Stephanie Bennett, MSIII

Tape # 2 *Use of Botulinum Toxin in Unremitting Post-Traumatic Muscle Hypertonicity*
Walter C. Ehrenfeuchter, DO, FAAO

Musculoskeletal Manifestations of Operative Complications and Manipulative Management of the Post-Operative Patient
Daniel L. Wisely, DO, FACOS

Tape # 3 *Effects of Manipulative Treatment on Computer Enhanced Somato Sensory Evoked Potentials*
Alexander S. Nicholas, DO, FAAO

Characteristics of the Cranial Rhythmic Impulse in Healthy Humans
James M. Norton, PhD

Tape # 4 *Getting What They Owe Us: Coding and Collecting for OMT*
Judith A O'Connell, DO

Tape # 5 *Psoriatic Arthritis*
Barry Getzoff, DO

Cutaneous and Soft Tissue Manifestations of Occult Spinal Dysraphism
Patrick Coughlin, DO

Tape # 6 *Physiologic Mechanism for the 'Red Reflex' Skin Response*
Charlotte Greene, PhD

Cutaneous Manifestations of Somatic Dysfunction
Frank Walton, DO, FAAO

Check the set of tapes which you are ordering and enclose a check for the appropriate amount made out to The American Academy of Osteopathy.

_____ Complete Set @ $99.95 plus $10 P/H

_____ Tape #4 Getting What They Owe Us: Collecting for OMT @ $29.95 plus $5 P/H

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Tapes are 1/2 inch VHS-USA standard format. Call for quote on other formats.

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City State Zip

Telephone

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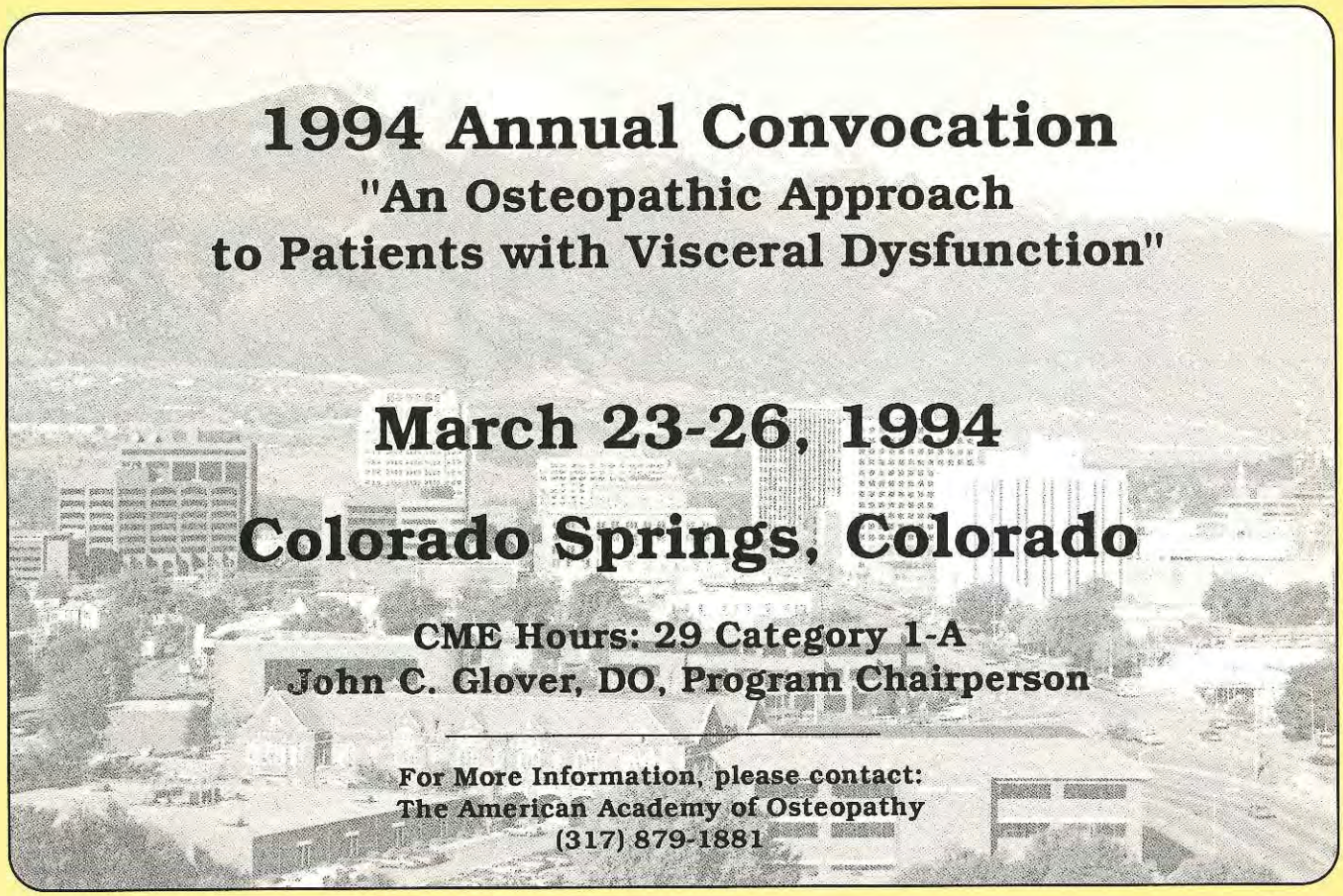

1994 Annual Convocation

"An Osteopathic Approach to Patients with Visceral Dysfunction"

March 23-26, 1994

Colorado Springs, Colorado

CME Hours: 29 Category 1-A
John C. Glover, DO, Program Chairperson

For More Information, please contact:
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(317) 879-1881

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