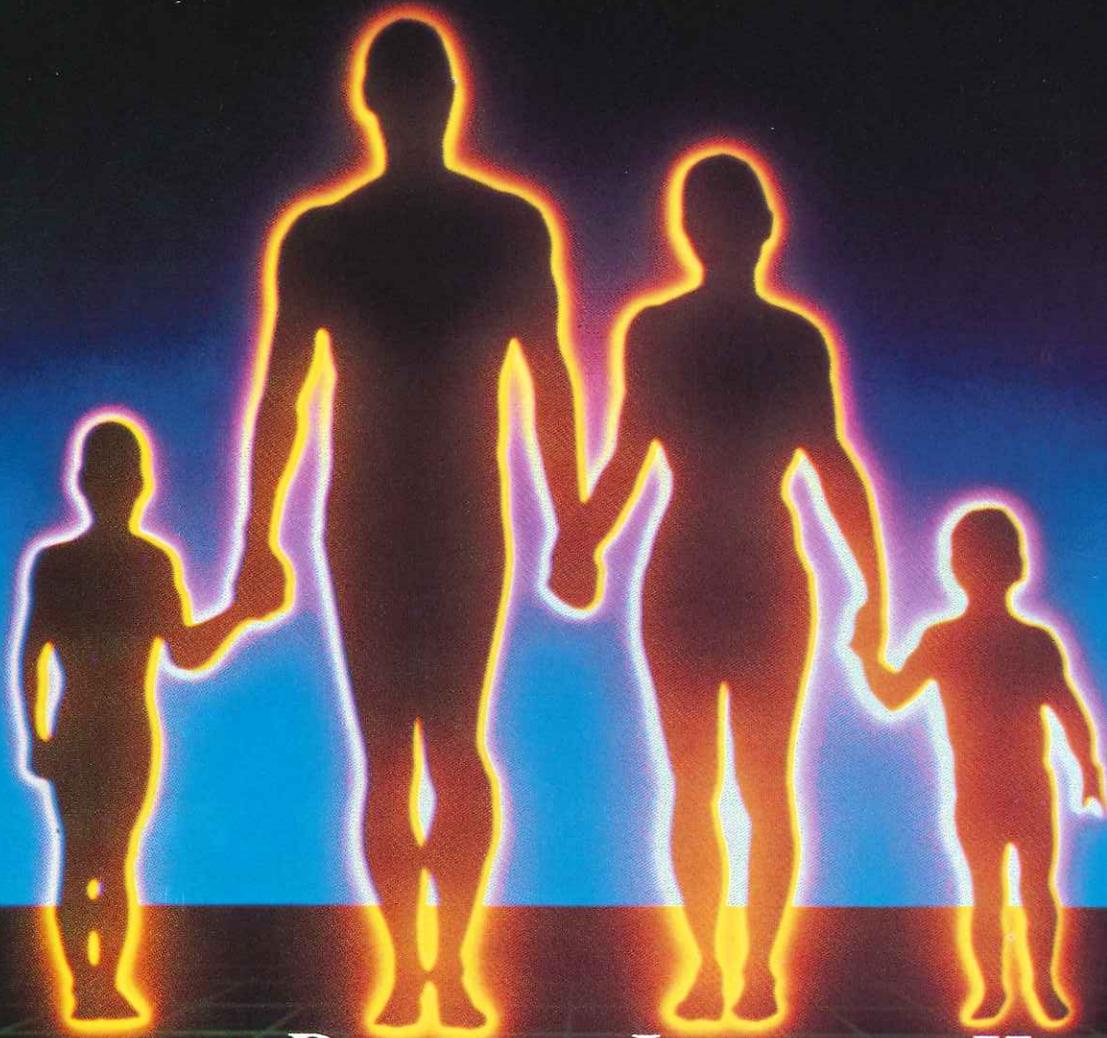


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JOURNAL
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The mission of the American Academy of Osteopathy is to teach, explore, advocate, and advance the study and application of the science and art of total health care management, emphasizing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

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STORIES THAT MUST BE TOLD

I have a friend who tells me that I don't read enough novels. For her, literature is a way to unwind at the end of a busy day, to relieve stress, and to allow an author to take her to a place she's never been before. And while it's never come up in conversation, I feel certain she would argue that physicians can learn a lot about the art of medicine by reading literature that tells of patients' struggles with illness.

Now I have no quarrel with literature. I studied quite a lot of literature in high school and college. Even now I am currently plowing through a volume of T.S. Eliot's essays on literary criticism, and another one on the analysis of French symbolist poetry. I would also not argue against the fact that, as physicians, we could learn much about patients by studying pathographies (as we call them), those personal accounts of patients' experiences with their diseases and with the world of medicine.

But over the years I have come to have more 'fun' reading things of a more technical, scientific or academic nature. I somehow feel I learn more from material of this nature than I do from novels. Sometimes I wonder why it is that I have grown away from literary pursuits and more toward technical knowledge. I'm sure there are many reasons, but certainly one of them is this: my patients' lives are like literature to me. When I listen to my patients, what I get is not just a litany of complaints, but a literary account, in their own words, of their fears, concerns, hopes, dreams. They tell me in their own way about their lives into which disease has intruded.

When patients give us information and answer our questions, we try hard to extract from these facts the elements that make medical sense, that help us to develop a diagnosis and a treatment plan. This is the stuff that goes into the medical record, the kind of thing that makes up the 'case study'.

But we need more than case studies. We must listen to the life stories our patients tell us. These are stories that must be told. They help us to shape our clinical judgment, and telling the story is as important a part of the patient's therapy as any manipulation, medication or diagnostic test. As Kathryn Montgomery Hunter tells us, "knowledge of cases sharpens the awareness of clinical possibilities; knowledge of life stories helps cultivate attention to patients, an interest in their oddities and their ordinariness-- and a tolerance for both."

So listen carefully and attentively to your patients' stories, for these are what bring a dimension of excitement and adventure to the practice of osteopathic medicine. Explore the world of medical literature, but remember that there is literature in the narrative account that each and every patient offers you. Soak it in, and you will be all the better for it. □



LETTER TO THE EDITOR

I enjoyed "Primary and Secondary Respiration" by Robert P. Lee in the last issue of the AAO Journal. I look forward to "Part II", complete with cited references, in the next issue. I think we need to acknowledge there are more than two models of CNS motility, however. Many groups talk about "inherent motility in a "bioenergy" perspective, from Chinese Ch'i to chiropractic innate. Barb Briner has introduced the AAO model through her Baily workshops.

I draw parallels with medical organology. Reich (1949) asks, "Does the brain move? Does it contract and expand when working just as other organs, such as the heart?" Konia (1980) answers, "Subjective confirmation of brain movement can be obtained from individuals who are free of armoring... this movement is relatively slow and unrelated to arterial pulsation." I think many diverse groups are talking about the same phenomena. Hopefully, cranial osteopathy can serve as the Rosetta Stone, enabling a myriad of disciplines to understand each other. □

John M. McPartland, D.O., M.S.
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East Lansing, Michigan

1. Konia, C., 1980, Brain Pulsations - Part I: Normal Functioning. *J. Organomy* 14:103-113.

2. Reich, W., 1949, *Character Analysis*. Orgone Institute Press, New York.

"They (the osteopaths) are the champions of natural law"
- A.T. Still *Autobiography*

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. Hruba, DO, FAO, 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.

Computer Disks

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

Illustrations

1. Be sure that illustrations submitted are clearly labeled.
2. Photos should be submitted as 5" x 7" glossy black and white prints with high contrast. On the back of each, clearly indicate the top of the photo. Use a photocopy to indicate the placement of arrows and other markers on the photos. If color is necessary, submit clearly labeled 35

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3. Include a caption for each figure.

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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.

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Stephen J. Noone, CAE

This month marks the completion of my first year as Executive Director of the American Academy of Osteopathy. I continue to be delighted with the opportunity to serve AAO members whom I believe to be the "heart of the profession." I have never regretted my decision to aggressively pursue this position and have welcomed the challenges which continue to present themselves daily at the Academy. I look forward to the 1993 Convocation in Dallas where I can interact with you on a variety of issues.

AAO President **Judith O'Connell** represented the osteopathic profession at the American Medical Association's CPT Editorial Panel Meeting on February 6 at Lake Tahoe, NV. Dr. O'Connell made a presentation on behalf of a Task Force on Manual Medicine to advocate the inclusion of osteopathic manipulation codes in the 1994 edition of the *CPT Manual*. Also in attendance at this meeting were **Robert Lee Peters, Jr., D.O.**, a general practitioner from Round Rock, TX, who is the AOA's liaison to the CPT Panel and **Betsy Beckwith**, AOA's Director of Government Relations. Since the Panel considered more than 1,000 new codes at this latest meeting, there is no report at press time whether the Panel has approved the inclusion of OMT codes for the 1994 *CPT Manual*.

Dr. O'Connell presented the following codes:

Osteopathic Manipulative Treatment (Proposed)

The following codes are to be performed directly by a physician and surgeon in conjunction with multi-system medical/surgical evaluation and management of the patient.

Evaluation and management services performed in conjunction with OMT should be reported separately.

Body regions are defined as head, cervical, thoracic, lumbar, sacrum, lower extremity, upper extremity, pelvis, ribs, abdomen and viscera.

Potential CPT Codes	Procedure Description
# 1	OMT one to two body regions defined
# 2	OMT three to four body regions defined
# 3	OMT five to six body regions defined
# 4	OMT seven to eight body regions defined
# 5	OMT nine to ten body regions defined

I must emphasize that this proposal is just that — a proposal placed before the CPT Editorial Panel. What happens next? If the Panel approves the codes for inclusion into the *CPT Manual*, the codes go before the AMA's Relative Value Updating Committee (RUC) for assignment of work values and calculation of reimbursement levels.

The Agency for Health Care Policy and Research (AHCPR) and the Low Back Problems Guideline Panel have asked the Academy to nominate a representative to serve as a peer reviewer of the draft guideline. Since **Stephen Blood** testified before the panel last September as the Academy's spokesman, AAO President **Judith O'Connell** nominated Dr. Blood. As peer reviewer, Dr.

Blood had to sign a confidentiality and consent agreement. He and the Academy will be acknowledged as participants in the final publication.

The AHCPR was established in December 1989 by Public Law 101-239. It is one of eight agencies of the Public Health Service in the Department of Health and Human Services. Within the AHCPR, the Office of the Forum for quality and Effectiveness in Health Care (the Forum) was established. The Forum facilitates the development, review and update of clinically relevant guidelines which are intended to assist health care practitioners in the prevention, diagnosis, treatment and management of clinical conditions. These guidelines are developed by an independent panel of experts and consumers assisted by AHCPR. Two osteopathic physicians served a full members of the panel: **John L. Hart** of Missouri and **James Weinstein** of Iowa.

In other AHCPR news, you will recall from my report on January 8 that the Academy nominated Drs. **Stephen Blood**, **Barbara Briner** and **Michael Kuchera** for consideration to appointment to the AHCPR panel to identify topics in musculoskeletal disorders. However, AOA President **Edward Loniewski** has forwarded the name of **Terry J. Weis, D.O.**, FAOAO to AHCPR as the profession's representative. Dr. Weis is an orthopedic surgeon from Chesterfield, Missouri who was nominated by the American Osteopathic Academy of Orthopedics.

The January 29th meeting of the American Osteopathic Association's Council on Federal Health Programs featured a "congressional-style debate" on health care reform. Council Chairman **Marcelino Oliva** and the AOA's Washington Office staff presented the major elements of health care reform measures as proposed by President Bill Clinton, the American

Medical Association, the American Academy of Family Practice, etc. Participants then had the opportunity to make presentations to convince the Council on how the osteopathic profession should attempt to shape this reform.

AAO President-elect Herbert Yates received applause from other practice affiliates after he spoke on behalf of the Academy. His effective testimony included the following:

"You (the members of Council) have the opportunity to champion the message that osteopathy is the bridge between traditional and alternative medicine. DOs have been holistic, patient, prevention, and health oriented long before these were 'buzz words.' We are the only profession capable of bridging of all phases of health care. From cradle to old age, from prevention to the most advanced interventional therapies, from general to specialist, from traditional to the most innovative, from rural to interurban, yet at all levels in all ways holistic, healing, patient-centered care. We provide primary care at its best.

"We are the true gatekeepers, the DOs who use osteopathic manipulative principles in our practices, including OMT.

"I am confident that you (the Council) will insure that regulations will be included in any managed care legislation that require all managed care systems to include OMT as a covered service that is non-capitated."

Following the appointment of Hillary Rodham Clinton to chair the Health Care Reform Task Force, AAO President Judith O'Connell wrote to Mrs. Clinton to offer the assistance of the Academy to the Task Force as it seeks to accomplish its ambitious task. She emphasized the AAO mission and the fact that Academy members are the appropriate gatekeepers in the health care delivery system since they extensively utilize osteopathic manipulative medicine in their practices.

Dr. O'Connell has called for all members of the Academy to write to Mrs. Clinton, their senators and congressmen to advocate the inclusion of osteopathic medicine as basic cover-

age in the health care reform package which is developed by the Task Force within its 100-day timetable. All AAO members received a letter from Dr. O'Connell and a draft letter for Mrs. Clinton and Congress which physicians can use as a model for their personal communications. Please act on this matter immediately!

The Academy's Education Committee assisted the AAO staff in holding an Open House at the society's headquarters in Indianapolis on February 5. The event presented a delightful opportunity to show off the new offices and to enlighten visitors on the role of osteopathy in the national health care delivery system.

The following Education Committee members took part in the event: **Boyd Buser, Mark Cantieri, Anthony Chila, Walter Ehrenfeuchter, John Glover, Ann Habenicht, William Kirmes, Richard Koss, Melicien Tettambel, and Herbert Yates.** Several district managers of pharmaceutical companies attended the Open House and discussed potential sponsorship with program chairpersons in attendance.

Three Academy members toured the facilities: **Herbert Miller and James Shoemaker** of Zionsville, IN and **Harold Wackerle** of LaPaz, IN. The biggest hit among the physicians in attendance was the AAO library of rare books on osteopathy which are prominently displayed on built-in wooden bookcases in the conference room. Generally, guests were impressed with the first-class facilities and particularly enjoyed the scenic view of the city from the eighth floor of The Pyramids. □

SIGNS OF LIFE

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

I have been a very busy person in the last few months. I have been negotiating with HCFA/Medicare, NIH, and AMA/CPT. Please take my word for it, the Osteopathic profession is not dead! On the contrary, there are signs of life everywhere!

One of the most frustrating comments I hear from within our profession is that no one does OMT anymore. Everyone just seems to accept this misstatement as fact and act accordingly. In my travels within and without our profession, I have found evidence to the contrary. I would like to share one of these pieces of evidence with you today.

The Relative Value Update Committee (RUC) of the AMA has been tracking the use of codes by various specialties. Osteopathic Medicine (D.O.) is speciality code 97. At the most recent Council on Federal Health Programs meeting, the top 100 CPT procedures by specialty and frequency were released. Of the top 100 D.O. codes listed, REGIONAL MANIPULATION-97260 AND SUPPLEMENTAL MANIPULATION-97261 were ranked #18 and #6 respectively. Now some of you might say so what. I say yahoo!!! This document verifies that D.O.'s are not only using OMT, but are also billing for it!

I am sure that there are more documents like these out in the 3rd party carrier data base analyses. Since we are always berating ourselves for lack of documentation, I think that we need to look outside of our group and discover what everyone else knows--that D.O.'s are performing OMT in surprisingly high numbers.

You see, there are signs of life everywhere. We just have to open our eyes and look around! □

RESEARCHING THE EFFECTIVENESS OF OSTEOPATHIC HEALTH CARE IN PRACTICE: AGENCY FOR HEALTH CARE POLICY AND RESEARCH PLANS

Albert F. Kelso, Ph.D., Emeritus Professor of Osteopathic Medicine
Consultant, Louisa Burns Clinical Observation Committee

An innovative program to insure access to quality health care* for all citizens was initiated at the direction of Congress in 1989. The goal is to maintain quality in a cost-efficient* environment. The program envisions achievement³ through cooperation from all persons involved in health care delivery or use of health care resources.

The U.S. Public Health Service, Agency for Health Care Policy and Research (AHCPR) is responsible for coordinating Federal efforts related to this goal. Patient outcome research on practice, one of the Agency's programs is introduced below. A description of the practicing physicians' potential roles follows. The benefits that the Osteopathic Profession, American Osteopathic Association American Academy of Osteopathy and physicians using manual medicine can obtain as participants in the AHCPR in the Federal is discussed.

AHCPR. The agency programs encompass health management, delivery and care. Patient Outcome Research is one of the programs. All health care including manual medicine will undergo an intensive review for appropriateness* and cost-efficiency. Congress has directed that immediate action be taken in certain

aspects of the programs. It is possible that general or specific aspects of manual medicine will receive early attention.

Implementation of AHCPR programs anticipate that inappropriate practice patterns will be changed if relevant scientific evidence is effectively disseminated⁴ to health care providers and patients. The agency's research methods use data on practice outcomes as a measure of quality health care.* This shift does not eliminate traditional medical research. It does recognize that the same efficacy* obtained in research on interventions during clinical trials and other applied clinical research will not be as effective in the medical arena.

Several factors are different in the AHCPR approach from earlier Federal and State efforts to legislate osteopathic medical practice. The quests for evidence in the past implied that current research methods provide the information. Basic and clinical research conducted in idealized situations are not universally applicable to non-medical research. For example, patients and physicians can not be blinded to the administration of manual procedures. Nor is it feasible to control the "dosage" of administering manual procedures in

a manner similar to medical doses. The interactions between physicians and patients have more influence in manual than in medical interventions. Quality, measured by patient outcomes, will be studied by panels of experts for ineffective, inappropriate, unnecessary and unimportant health care procedures. Their deliberations converted to guidelines are used for decisions made by administrators, managers, patients and providers of health care.

The AHCPR patient outcomes program includes collecting data on the patient's needs for and satisfaction with health care. This in addition to measuring the effectiveness of outcomes observed in clinical practice. Note that the patient's expectations and satisfaction with health care greatly influence Federal and State regulations of health care.

Physician's Roles. Physicians, Medical and Allied Health Professionals anticipate AHCPR use of data from several sources. Public health statistics, reports and claims from practice are an available source of information. Research by the profession initiated to research physician's services will include input to surveys and reports on practice. This latter research is essential for comparison with ACHPR data. It is also useful in

* see glossary for definition of terms

planning physician education and monitoring professional activities.

Public health statistics provide information on mortality, morbidity, frequency of illness and accidents; and routine medical summaries and reimbursement claims provide information on patient benefits and complications. Surveys and reports provide specific information on patient data, such as, health needs, expectations and satisfaction with care. The physician's data in the survey indicate the interventions used, services provided and assessment of outcomes. Both public and professional data represent wide variations in accuracy and reliability.

The collection of personal data and creation of computer data bases always raise the issue, invasion of privacy. Aggregated data protects the privacy of the persons involved. However, the patient's and physician's information in surveys and reports is traceable to coded original records generated in practice.

The public health and related data are readily available. Difficulty in relating this data to specific practices or interventions offsets this convenience. The availability of data from physicians' practices insures that patient outcomes can be related to the interventions used in care. A disadvantage of survey and report data collected by the Profession or its agents is delay and quality control. Training and cooperation of practicing physicians can surmount these difficulties and insure availability of 'real life' data.

Information obtained directly from patients and the osteopathic physician's practice is potentially the better source. Direct evidence is reliable when data collection follows specific procedures and is accessible for verification. Professional information can be accumulated as a data base and used to assess physician

education, the community and public benefits as well as patient outcomes associated with osteopathic health care. The difficulty in obtaining this information from practice lies in lack of experience by physicians and the profession in collecting and reporting the information in a uniform manner.

Patient benefits obtained from osteopathic health care have not been examined by planned research protocols. Such research is now recognized as a potential source for making decisions to increase the availability and quality of health care. Measuring patient health outcomes with a planned protocol provides reliable data for decisions. These decisions will benefit the patient, the practicing physician, the Profession and the public.

The role of the AOA and AAO. Professional organizations have a leadership role in representing physicians' interests. Assignment of this responsibility is essential in ensuring that osteopathic manual medicine is represented in Federal decisions on health care. The AOA and AAO recently agreed to the AAO taking a leading role in the manual medicine component of osteopathic medical practice. Agreement that this role includes patient outcome research expedites planning and implementing the research.

The patients, practicing physicians, AHCPR and the Osteopathic Profession each have priorities that need to be considered.

The practicing physician faces many variables and demanding tasks, acknowledged difficulties that must be surmounted. The physician's role is supplying the data on patient's needs, care provided, outcomes and satisfaction. One method is completion of surveys or annual reports on practice when the task is not complicated by attention to patient care. An alternative is submission of an annual report or summary of the same infor-

mation accumulated as part of practice. In any choice that provides satisfactory input minimal disruption of the process of health care is a key consideration. Attention given to the practicing physician's priorities insures success in the research plan.

The public's, AHCPR's and Profession's priorities include linking the diagnosis and treatment of somatic dysfunction to patient outcomes. Clinical observations are difficult but not impossible to measure. Semi-quantitative measures of somatic dysfunction reflect small changes in its characteristics. Reliable estimates⁷ obtained by scoring and scales will demonstrate the association of changes induced by manual treatment with changes in health status. To avoid confusion use somatic dysfunction, a codable diagnosis, to describe the patient's neuromusculoskeletal condition and the focus of manual intervention.

Scores for each characteristic of mobility, structural asymmetry or tissue are summed to provide a numerical measure. Measures obtained in this manner track changes in somatic dysfunction. The selected set of measurements are validated by research. Studies demonstrate association between changes in measurements and clinical progress. What change occurs during the natural course of somatic dysfunctions, its course during treatment or during concurrent use of other interventions? Analysis will indicate the most sensitive measures and the time course of the changes. Physician's experience is that mobility and vasomotor changes occur even during manipulative treatment while structural asymmetry and tissue characteristics may not change immediately.

The initial professional survey may be a summary of the number of cases, the patient's needs for care, the physician's services and reported

outcomes of care. This survey and analysis should suffice to test the data collection method. Analysis of this data will indicate the strengths and weaknesses in the survey or reporting procedures. Modified or alternative solutions should be considered after the initial effort and analysis. The goal of revising data collection is to supply detailed information needed in reports within and by the profession.

"An immediate effort will preserve the philosophy and principles..."

An alternative to using practice data to evaluate patient outcomes is to use information from a patient's periodic health examination. The periodic health examination has become a routine part of general and family practice and is designed to identify and reduce patient health risks.⁸ This examination in osteopathic practice includes information on somatic dysfunction and its treatment. The examination can be scheduled to allow sufficient time to collect credible data using standardized procedures. The emphasis on assessment of health risks in periodic health examinations favors study of long term benefits associated with osteopathic manipulative treatments.

Another option is to develop survey teams to provide information on methods to be used in the surveys. The survey team is different than patient outcome research teams (PORT)⁷ which are made up of experts in multiple areas of health care. PORT teams conduct research on specific questions related to practice outcomes. Survey teams seek answers to questions on research design. Their studies provide information on measuring and reporting clinical procedures.

Examples of specific questions

for survey teams include procedures to be developed, the standardization of diagnosis of somatic dysfunction, the use of semi-quantitative measurements in order to detect changes in somatic dysfunction or development of uniform methods for recording and reporting osteopathic diagnosis and treatment. Other methods to be studied include development of methods to record patient expectations from osteopathic care, to obtain follow-up information from patient's concerning their satisfaction with osteopathic care.

PORT teams investigate very specific questions on patient outcomes. The intervention and the conditions under which it is used are well defined. An almost endless research series can be initiated to compare the patient outcomes for different interventions. For example, the relative effectiveness of osteopathic manipulative treatment with physical therapy or medical interventions.

Creating a data base provides an immediate source of information. It allows the initial data collected to be reviewed or modified as data collection procedures are improved. A data base is a source of data for retrospective review on the long term effects of somatic dysfunction and its treatment. This last consideration is important. Osteopathic philosophy has generated a principle of practice, "removing the dysfunctions of the neuromusculoskeletal system assists the body in resisting stress, and restoring and maintaining health." Data to support this principle will require longitudinal studies.

A challenge faces the AOA, AAO and osteopathic physicians practicing manual medicine during participation in Federal and AHCPH efforts. Acceptance requires a plan, assigning responsibility, tasks to be performed and a schedule for completion. This plan should address both

the urgent priorities faced by AHCPH as well as the needs of the profession for information. Success depends upon expert assistance to design the data collection instruments, complete the initial analysis, create a data base and reporting format. It also depends upon the participating physicians using quantitative measures to describe osteopathic diagnosis and treatment of somatic dysfunction and uniform records.

An immediate effort will preserve the philosophy and principles of osteopathic medical practice that make it unique in the field of manual medicine. They support the current reordering of health care goals to emphasis on health maintenance and risk reeducation in a cost-efficient environment. Responsible professional action guarantees patient benefits provided by practicing physicians. Also, this action assures a source of information on the Osteopathic Professions' contributions to medicine, the community and public.

Summary. The Federal Government has supplemented earlier efforts to provide access for all citizens to quality health care with an additional effort to establish a cost-efficient environment for these efforts. The AHCPH which has responsibility for integrating the governmental efforts in health care research has included the study of patient and physician data on effectiveness of interventions used in practice. The AHCPH now issues guidelines on interventions needing study for ineffective, inappropriate, unnecessary and unimportant interventions. This change is preferred to regulations created by individuals who are not providing patient health care. The new approach provides organizations and clinicians with the opportunity to be represented in decisions on future health care.

Can planning, implementing and

reporting the profession's data be completed on a timely basis? Will osteopathic physicians be willing to provide uniform records of osteopathic diagnosis and treatments that can be utilized to detect changes associated with both immediate and long term changes in patient health status? Past experience indicates that patient's interest and support can be counted upon. The profession and its physician can repay a century of indebtedness to previous patients whose support has established osteopathic medicine as a full practice profession and insure the same or even improved quality of health care for future generations.

NOTES AND REFERENCES

1. The AAO Noone News Report in November 1992 reported that Drs. O'Connell, Frymann and Patterson attended a meeting at the request of the National Institutes of Health - Unconventional Medical Practice Workshop.

Their attendance insured that osteopathic physicians who include osteopathic diagnosis and treatment of somatic dysfunction in their practice were represented. They joined other providers whose health care services involve non-medical interventions to discuss the Federal Mandate that requires research on effectiveness of management and practice in order to improve health care and provide information for cost containment.

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DEFINITION OF TERMS FOR PATIENT OUTCOME STUDIES

Efficacy - the effects of an intervention observed in controlled research studies.

Effective - the effects of an intervention observed in patient outcome studies.

Cost-efficient - the relative cost for interventions that provide similar patient benefits.

Appropriate - patient benefit to risk ratio that is acceptable for the condition treated.

Quality health care - health care that provides an effective, appropriate, necessary and important benefit for the patient. □

CONVOCATION SPECIAL EVENTS - 1993



Time to
Jazz Things Up
a Little

- **Wine & Cheese Reception - La Gala Room**
Tuesday, March 23, 7:00 pm - - open to registrants and guest
- **Spouse/Guest Breakfast - Monte Carlo Room**
Wednesday, March 24, 8:00 am - - Breakfast and program for spouses and guest of Convocation attendees. Speaker: Ann Blankenship, Ph.D., R.D., L.D., "Shopping for Nutrition". Tickets \$15 per person.
- **Reception - Garden Court**
Friday, March 26, 6:30 pm - - cash bar one hour reception preceding the Banquet.
- **The Banquet - Malachite Room**
Friday, March 26, 7:30 pm - - Awards to be presented include the A.T. Still Medallion of Honor, the Academy's most prestigious honor. The ceremony also includes the induction of the new AAO President, Herbert A. Yates, DO, FAAO. Comments will be made by AAO President Judith A. O'Connell, DO and AOA President Edward A. Loniewski, DO.
- **Jazz and Dancing - Malachite Room**
Friday, March 26, 10:00 pm - - entertainment provided following the banquet by The Marchel Ivery Quartet/Quintet, a jazz band from Dallas. Cash bar will be available. Purchase tickets in advance from the Academy office for \$5.00 per person.

WILLIAM ANDERSON, D.O. DELIVERS KEYNOTE ADDRESS

CHICAGO, IL—William G. Anderson, D.O., a trustee of the American Osteopathic Association, delivered the keynote address at the National Health Screening Fair on October 5, 1992 in Washington, D.C. Dr. Anderson's speech kicked off the conclusion of the 16-month celebration of the hundredth anniversary of osteopathic medicine.

To an emotionally aroused audience, Dr. Anderson talked about the history of osteopathic medicine and what it stands for. "While we celebrate the centennial of a great profession, we will not forget that with the honor and privilege comes obligation and responsibility. We will not forget our rich heritage nor shall we ignore the present nor fail to prepare for the future." Dr. Anderson continued with, "to deny anyone access to adequate healthcare in America shall be our eternal shame. The osteopathic profession will be in the forefront of making us a proud and healthy nation."

The audience was moved as Dr. Anderson talked about the shame that hovers over American medicine with more than 37 million Americans that don't have access to adequate healthcare. He also talked about how the fetal mortality and morbidity rate exceeds that of some third world nations.

Dr. Anderson also shared his feeling about Andrew Taylor Still, the founder of osteopathic medicine, "A.T. Still was a medical pioneer, he

had a philosophy that yet defies adequate definition, but a philosophy that has proven itself by results. A philosophy that now spans a century and practiced by over 33,500 osteopathic physicians."

Dr. Anderson concluded his dynamic speech with these closing remarks, "Yes, we will prescribe the medication, we will preform the surgery, we will deliver the babies. But we will also show that we care about the family, the home, the schools, crime, drugs, hunger, poverty and homeless, because we are osteopathic physicians rooted in a philosophy and a practice that says, We Care!"

..."to deny anyone access to adequate healthcare in America shall be our eternal shame"...

An AOA trustee for the past nine years, Dr. Anderson has chaired the AOA's strategic planning committee and the bureau of state government affairs. He served as president of both

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his county and state osteopathic medical associations and has received numerous awards such as the Physician of the Year, given by the Michigan Association of Osteopathic Physicians and Surgeons, Inc.

Dr. Anderson is a 1956 graduate of the University of Osteopathic Medicine and Health Sciences, College of Osteopathic Medicine and Surgery, in Des Moines, Iowa. He was a general surgeon for 17 years before becoming a hospital administrator. Today, Dr. Anderson is the director of governmental affairs at Detroit Osteopathic Hospital and president of LifeChoice Quality Health Plan, HMO in Detroit. □



Lower Back Pain In An Elderly Patient With Complicated History

BOYD R. BUSER, D.O.

A person's ability to compensate for chronic disease processes may allow that patient to lead a relatively asymptomatic existence in spite of the chronic disease state. A small additional stress may cause a breakdown of these compensatory mechanisms; the "straw that broke the camel's back". This case was chosen to illustrate the attempt to restore the patient's ability to compensate for their chronic disease. It also demonstrates the efficacy of focused and carefully applied thrust mobilization in a frail patient.

REPORT OF CASE

A 67-year old white female presented to the clinic with a chief complaint of pain in the right lateral hip, extending to the proximal right thigh. She stated that the onset of these complaints was gradual beginning approximately two years ago without any inciting event. She had described the discomfort as more of a "nuisance" than a debilitating pain. Recently, however, she had begun to experience an increasing sense of instability in the right hip area which had recently required her to ambulate with the aid of crutches. Her past history was significant for rheumatoid arthritis which was diagnosed at the age of 18, and for which she has undergone multiple therapies including oral Prednisone for the past 30 years on a daily basis as well as intermittent gold therapy. She also stated that she had polio as a child, which affected both lower extremities; the left more than the right. There was also a history of severe degenera-

tive joint disease in the lumbar area and right hip for which she underwent a total hip replacement approximately 5 years prior. Her past surgical history was positive for right hip prosthesis surgery as described above. She denied any known medication allergies. She stated that her present medications include: Prednisone 10mg/day as well as Naprosyn 500 bid.

Examination revealed an alert and oriented white female who appeared older than her stated age. She ambulated adequately with the use of crutches. There was a significant torsional deformity noted in the mid-lumbar region with the upper lumbar rotated toward the left and the lower lumbar rotated toward the right. There was a slight increase noted in the thoracic kyphotic curvature. The upper cervical complex exhibited left rotation and the cervicothoracic transitional area was rotated toward the right. Chronic tissue texture changes were noted throughout the lumbar paravertebral musculature, most prominently in the lumbar region. There was muscle atrophy noted in the left leg. The right lower extremity was apparently 1 1/2 inches shorter than the left. The right shoe had been built up on the sole and heel to accommodate this limb length discrepancy. The range of motion of both hip joints was essentially within normal limits. There was a marked distortion of the pelvis with the right innominate rotated anteriorly. The sacroiliac joints were restricted bilaterally.

X-rays, brought with the patient, revealed severe spondylitic changes in the lumbar spine with obliteration of the disc space at L2-3. There was fusion noted at this level, at an angle of rotation of approximately 30°. There was also complete spondylitic fusion of the L5-S1 level. There was apparent osteopenia noted throughout the bony structures. Assessment of this patient included:

1. Chronic somatic dysfunction of the sacroiliac joints.
2. History of rheumatoid arthritis.
3. Degenerative joint disease with fusion in the lumbar spine and prosthesis of the right hip.
4. Post-polio muscle atrophy.
5. Generalized osteoporosis aggravated by longterm steroid use.

Osteopathic manipulative therapy was rendered utilizing thrust mobilization in the cervical, thoracic, and lumbar areas. Indirect myofascial release technique was also utilized in the lumbar and right lower extremity regions. The amount of mobilization attained at the initial visit was quite limited. The patient was instructed to return to the clinic for reevaluation in two weeks.

At the time of the return visit, the patient was noted to be ambulating normally without the use of crutches. She stated that the right lower extremity pain was completely resolved. She continued to experience some discomfort in the right flank region, but this was improved over the previ-

ous visit. This patient remains under my care and has progressed to the point where she is now essentially asymptomatic with respect to her lower back, right hip, and right lower extremity. I continue to see her approximately once every two months for maintenance care.

DISCUSSION

This case illustrates several aspects of the manipulative treatment of the elderly patient with chronic disease. In spite of chronic disease which had been present for years, this patient had been asymptomatic with respect to her low back, pelvis, and right lower extremity, until a seemingly insignificant event triggered an onset of symptoms. In fact, during the initial evaluation, the patient had been unable to relate any sort of traumatic event to the onset of her symptoms. However, as time went on, she was

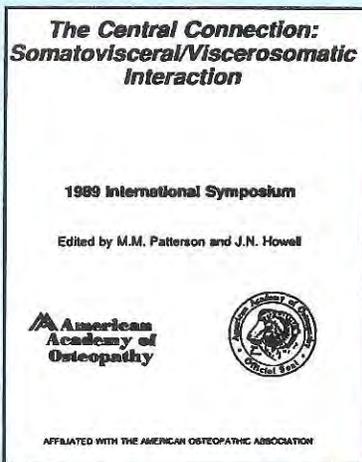
able to remember a "bumpy ride" in the woods while visiting family members. She had very minimal discomfort at that time, but over a period of the next two years, it gradually increased to the point where it became debilitating and the need for crutches to ambulate gradually developed. The patient had an ability to compensate for her multiple dysfunctions until this minor event overtaxed those compensatory abilities. In spite of the fact that very limited mobilization was achieved on the initial visit, enough improvement was made to allow her compensatory mechanisms to function better. Hence, a significant improvement in symptoms from seemingly minimal intervention.

This patient's history and x-ray evaluation would seem to be a relative contraindication to the use of HVLA techniques. However, properly applied thrust mobilization should occur within physiologic ranges of

motion. Carefully focused application of force was utilized quite successfully in the management of this patient. She did not experience any significant post treatment soreness or other untoward affect of her osteopathic manipulative treatment. After being maintained on a dose of 10mg of Prednisone daily for approximately 30 years, this patient now is taking only 2.5mg of Prednisone daily. She is able to exercise more regularly and expresses a feeling of overall much improved health. □



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The Central Connection: Somatovisceral/Viscerosomatic Interaction

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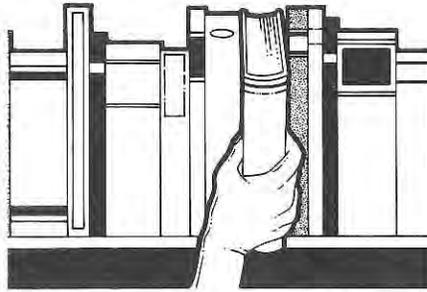
CASE OF BIRTH INJURY OR CRANIAL TRAUMA

H.A. Lippincott, D.O.

An interesting case of birth or early post-natal injury came under cranial treatment in March, 1945, at the age of two and a half years. The symptoms had appeared during the second year and the child, a little girl, had been through the usual examinations and diagnostic procedures in hospitals under the service of specialists of high rank. There was no uniformity of diagnosis, her condition having been attributed to cerebral palsy from birth, progressive muscular dystrophy, and Landry's paralysis.

The patient is the youngest of four children. The parents and two brothers are apparently normal and the second child, a boy, had the atrophic type of progressive muscular dystrophy and died a little over a year ago at the age of sixteen. So far as the parents know the birth of the little girl was normal. There is the usual history of falls, one in particular at six months of age when she had a severe bump on the head. Whether this injury or an unresolved molding of the head from birth was the etiological factor the outlook was definitely unfavorable.

At the time of first examination the child seemed to be of about normal intelligence and noticeably cheerful. Her muscles were of average contour, flabby, yet the reflexes were slightly exaggerated. The head drooped forward, she had propulsion gait and she lost her balance and fell forward after only a few steps. There was a great deal of drooling. She was subject to fainting spells followed by



muscular twitching and extreme exhaustion. Speech was practically unintelligible. Apparently there was considerable discomfort in the head for she would intentionally and repeatedly strike the back of it against the floor or whatever was behind her. She was subject to head and chest colds, croup, and attacks of strangling; x-rays showed no enlargement of the thymus. The symptoms were growing progressively worse.

Treatment of the case was undertaken with little encouragement to the parents as to prognosis. The cranial lesions were related especially to the base and posterior fossa of the skull and their reduction and the subsequent molding was followed by marked improvement. The epileptiform seizures stopped almost immediately, posture and locomotion improved rather rapidly over a period of several months, progress becoming more gradual since that time, and the rest of her symptoms have practically disappeared. There is a slight impairment of speech which may be partly from habit. She entered school last fall and engages in all the usual activities, running, dancing and playing

with the other children. It is only during periods of fatigue that slightly impaired control of balance and some drooling reappear. The head is still tender enough to require care on the part of the mother in washing or brushing it.

Apparently this case was following the pattern of progressive muscular dystrophy caused by cranial trauma affecting intracranial structures and the endocrine system. Had it been of purely hereditary origin it is doubtful if the response to treatment would have been as satisfactory. Fortunately the cranial lesions were corrected before much degenerative change had taken place in the central nervous system and the muscle tissue so the recovery was comparatively prompt. Whether it will be complete remains to be seen but the improvement has continued during the past year when she was given only one series of treatments, seven in all, in September and October. Remissions have been slight, always from a demonstrative cause.

The onset of symptoms and the progression during the first year of the disease were strikingly similar to that of her brother but the change since that period has been in striking contrast to the pitiful spectacle of his wasting away without benefit of treatment. □

This article first appeared in the AAO Yearbook, 1948.

LETTER TO A. T. STILL

Dear Dr. Still,

In my last letter I mentioned some of your comments on the topic of ear wax. You had some very interesting things to say about this substance, and you seem to have discovered a therapeutic use for it. Yet most people would consider this a rather cryptic topic, to say the least, as there doesn't seem to be much interest in ear wax in the world of modern medicine.

In your book, The Philosophy and Mechanical Principles of Osteopathy, you seemed to have the most success with diseases of the throat and lungs by using a combination of osteopathic treatment along with moistening the very hard, dry ear wax you found in these conditions. The ear wax was usually softened by using soap and water or glycerin. For example, you described treating a child with croup who, after your treatment, "coughed up phlegm easily, and when the dreaded hour, ten o'clock at night, all danger had passed."

Recently, while doing some journal reading, I came across a short article describing something called "Allen's reflex." Apparently, when trying to remove impacted cerumen from the ear, ENT specialists have noticed that the tympanic membrane is invariably stimulated as well. This manipulation of the tympanic membrane causes patients to cough involuntarily. I found this very interesting, to say the least. Could it be that your combination of softening the ear wax with glycerin, along with osteopathic manipulation, caused the patient to cough up phlegm, thus improving respiration, and venous and lymphatic

drainage? These phenomena, in turn, would allow the patient to overcome illness.

In any event, there seems to be some correlation here between Allen's reflex as it is known today, and your approach to certain respiratory ailments by dealing with the properties of ear wax. Just thought you might like to know.

Your ongoing student,

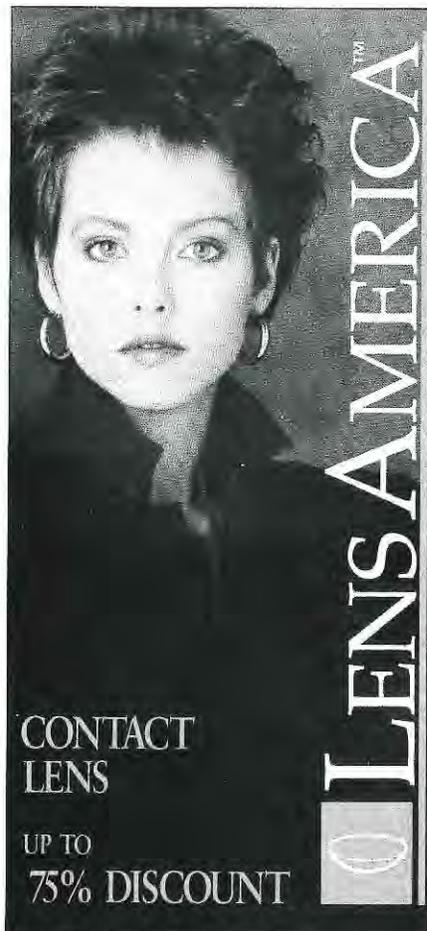
Raymond J. Hraby, D.O., F.A.A.O.

A.T. STILL MEDALLION DEADLINE NEARS

Please remember that if you wish to submit the name of a candidate for the 1994 A.T. Still Medallion of Honor Award, the deadline is April 15, 1993.

Deserving members of the Academy who shall have exhibited among other accomplishments in scientific or professional affairs an exceptional understanding and application of osteopathic principles, and of the concepts which are the outgrowth of those principles, may be awarded the Andrew Taylor Still Medallion of Honor. The Academy cherishes this award as its highest honor, and all petitions are considered confidential.

If you have any questions or need any additional information about this procedure, please contact the Academy office or refer to page 107 of your AAO 1992 Directory.



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PRIMARY & SECONDARY RESPIRATION

PART II

ROBERT P. LEE, D.O.

Mobility of the Cranial Bones, Membranes, and Sacrum

The motions of the cranial bones and sacrum are palpable by those who are trained. These movements are passive, in contradistinction to the inherent motility of the CNS. What the operator feels to be asymmetric in these motions becomes the basis for treatment, using the cranial concept.

Movement of the cranial bones is permitted by the sutures of the skull. A series of studies performed by Retzlaff^(43,44,45) et al at MSU-COM demonstrated the nature of the sutures and the movement of the parietal bones of the squirrel monkey. They showed that the sutures are filled with loose connective tissue, blood vessels and nerves, and are certainly not fused, as many anatomy books would indicate.

Using electromechanical transducers on the parietal bones of the squirrel monkey, they were able to record regular movement which was independent from respiration and cardiac pulsations.⁽²¹⁾ Another study by these investigators⁽⁴²⁾ demonstrated the function of the "core link", in which the sacrum and occiput are functionally related through the inelastic dural tube that extends from the foramen magnum to the second sacral segment. Except for the firm attachment at the second cervical vertebra, this strong connection between the cranium and sacrum is free to glide the rest of its length.⁽¹¹⁾ Retzlaff manipulated the sacrum of the animal, which created parietal motion, that his transducers recorded.⁽⁴²⁾

Sutherland recognized that form follows function, as he studied the details of the cranial sutures of a disarticulated skull. The temporoparietal suture is suited for gliding motion. The coronal suture for antero-posterior motion, and the sagittal suture for hinge-like motion. It is instructive that disarticulated skulls are produced by pressure from the inside out. Properly prepared whole skulls are filled with dry beans. When water is added, the beans swell, pushing the bones apart. No amount of force exerted against the intact skull will disarticulate it except from the inside out. Therefore, it is seen that the sutures allow expansion, but very little compression of the skull.⁽¹¹⁾

The intracranial membranes, the falx cerebri, falx cerebelli and tentorium cerebelli, maintain the skull in an intact state. Sutherland termed these the "reciprocal tension membranes". The falx cerebri that lies under the sagittal suture, and the tentorium cerebelli which lies horizontally and at right angles to the falx work in opposition to each other. In simplified terms, the falx restrains anteroposterior motion, and the tent, lateral motion. Although, these membranes permit change in shape of the cranial bones, they retain constant tension on their attachments throughout the cycle of flexion and extension. The fulcrum around which this cyclic cranial motion occurs has been termed the Sutherland fulcrum. The tent and the falx have their origins here, at this fulcrum, at the straight sinus.⁽¹¹⁾

Summary of Primary Respiratory Mechanism

To summarize the motions involved in the primary respiratory mechanism, consider flexion. The neural tube foreshortens by the contraction of the oligodendroglia. Secretion of the cerebrospinal fluid increases as the ventricles expand. The cranial bones allow for the change in shape of the central nervous system: the anteroposterior diameter shortens, the vertex elevates, and the lateral dimension expands. The sacrum moves posteriorly and superiorly at its base and toward the pubes at the apex. The reverse of these motions is noted at the other extreme of the cycle, extension.

Relationships of the Primary and Secondary Respirations

Anne Wales, D.O., in 1972 was quoted, "When we think of respiration, we ordinarily think of the lungs and heart in the thorax and of the diaphragm moving up and down with the alternating changes of shape during inhalation and exhalation. There is also tissue respiration; every cell in the body requires it for healthy function."⁽⁴⁷⁾

"The brain especially needs tissue respiration. The tissues in the floor of the fourth ventricle must be functioning efficiently for the body to live, because the vital processes of the body are located in the floor of the fourth ventricle. Among these is the respiratory center. This is why Dr. Sutherland came to call the whole

system he had discovered the primary respiratory mechanism."⁽⁴⁷⁾

Dr. Sutherland was quoted as saying, "While a student at the American School of Osteopathy..., during an idle stroll through the memorial hall, my attention was directed to the disarticulated bones of the skull that Dr. Still had on exhibition. The peculiar beveled articular surfaces relative to the greater wings of the sphenoid and the squamous portions of the temporal bones became especially interesting. Then, like a blinding flash of light, came the thought: beveled like the gills of a fish, indicating articular mobility for a respiratory mechanism."⁽⁴⁸⁾

Quoting Dr. Sutherland again: "I found that the cranial articular surfaces, throughout each little detail, indicated designment for mobility. Yet the idea still seemed irrational, and I became fearful in the thought of consultation with my ... colleagues, ... fearful of the danger of becoming an inmate in some mental institution. Yet the bug remained, and experimentation was commenced upon my own animate skull,...by establishing cranial lesions to ascertain the effects. A number of the effects proved quite serious. Others led the way, wherein a personal knowledge was obtained-a knowledge not obtainable by using a fellow man as the guinea pig. I found that the articulations did possess mobility, and not only the articulations, but also the brain, the intracranial membranes, the spinal cord, and the intraspinal membranes. I also found that the cerebrospinal fluid fluctuates, rather than circulates; and that the entire mechanism possesses a movement rhythmical to respiration, including mobility of the sacrum between the ilia."⁽⁴⁸⁾

The motion of both the primary and secondary respirations in inspiration involves a straightening and lengthening of the midline structures.

The lumbar spine flattens, the thoracic spine straightens, the vertex of the cranium elevates, and the sacrum flattens. Bilateral, paired, structures externally rotate. The extremities, temporal bones and ilia are seen to move inferiorly and externally on the anterior surfaces. During exhalation, the midline and paired structures move in directions opposite to the above.^(10,11)

The primary and secondary respirations facilitate each other. A deep breath increases the amplitude of the craniorhythmic impulse. (CRI)⁽⁴⁹⁾ A CV-4, a technique to momentarily dampen the CRI may change the rate and depth of diaphragmatic excursions.⁽⁵⁰⁾ Dr. Sutherland described a technique that he employed in the case of a drowning victim, and that could be utilized in electrical shock as well. When no vital signs are apparent, the cranial mechanism is found in extension. Dr. Sutherland firmly induced the temporal bones to externally rotate in a slow cyclic fashion. This helped to re-establish the craniorhythmic impulse, and soon cardiac and pulmonary activity resumed. This resuscitative technique is not recommended to the exclusion of other measures. However, it graphically demonstrates the relationship between the primary and secondary respirations.⁽⁵¹⁾

Both primary and secondary respirations facilitate the return of lymphatic fluid and venous blood to the heart. A CV-4, a special cranial technique, will reduce peripheral edema. A lymphatic pump which utilizes the diaphragm⁽⁵¹⁾ is also seen to reduce pedal edema.

The transverse diaphragms, including the thoracoabdominal diaphragm, the pelvic diaphragm, as well as the cervicothoracic junction and the tentorium cerebelli must move harmoniously, in order for the fluctuation of the CSF to be unimpeded.

If there is restriction in these transverse diaphragms of fascia, the wave propagating from the central nervous system through the tissue fluids will develop interference patterns as it meets these restrictions. Therefore, it is necessary to treat restrictions of motion of the secondary respiratory system, especially the thoracoabdominal diaphragm, in order that the primary respiratory mechanism⁽⁵²⁾ will function properly.

Another relationship between these two systems is demonstrated by the mechanism that regulates secondary respiration. In the floor of the fourth ventricle, the respiratory center is influenced by and has influence over the substances transported within the cerebrospinal fluid. The pumping action of the diaphragm, influences the CO content of the blood, which determines the activity of the respiratory center in the floor of the fourth ventricle.⁽⁵³⁾

Primary respiration exchanges waste products and physiological constituents between the central nervous system and the cerebrospinal fluid. Transport in the CSF to the periphery then allows an exchange of these substances between the CSF and the peripheral tissues. In parallel fashion, secondary respiration utilizes blood instead of CSF as the transport medium. Exchange first occurs between the ambient air and the blood, and then between the blood and the tissues of the body.

Treatment

For pulmonary respiration the operator directs his/her attention towards all components of the system. Diaphragmatic motion must be unimpaired. Therefore the xyphoid, lower six ribs and the attachments to the lower six thoracic vertebra must all be free. L1 through L3 must be free in motion. The quadratus lumborum and its association with the ilia must be

balanced. Likewise, the psoas and the attachments thereto at the lesser trochanters of the femurs must be functioning symmetrically. The sacrum lying between the ilia must be balanced in its movement and its core link to the cranium necessitates inspection of the head. The upper and lower extremities which are influenced by their attachments to the thorax and the pelvis must also be examined for any restrictions of motion. The innervation of the diaphragm by the phrenic nerve requires an inspection of its roots at cervical vertebrae three through five. Considering the vagal influence on respiration, the occipito-atlantal junction must be examined. With regard to the sympathetic nervous system that influences respiration, all thoracic vertebrae must be examined. Of course, since the sympathetic chain ganglia overly the transverse processes of all thoracic vertebrae, the bony thorax and the muscles of respiration must be considered in any treatment of pulmonary respiration. Thus, we can see that we must treat the entire physical body from head to the extremities when considering pulmonary respiration.

Indications for treating the pulmonary system include respiratory disease. Chronic obstructive pulmonary disease, pneumonia, asthma and bronchitis are all benefited by freeing the various components of external respiration. Furthermore, peripheral edema can be reduced through the improvement of lymphatic flow by freeing the diaphragm. Frequently, low back pain will involve some restriction of motion of the diaphragm because of its association with the psoas and quadratus muscles. Shoulder and arm pain are associated with thoracic spine and rib dysfunctions in which respiration may be compromised. Headache may be associated with dysfunctions of the diaphragm,

sternocleidomastoid, or scalene muscles. Emotional shock or withholding of emotions are also associated with restrictions of the diaphragm. In traumatic injuries, such as automobile accidents, a gasp of fear at the moment of impact may be retained as a dysfunction of the diaphragm. Diminished excursions of diaphragmatic motions are seen clinically in people who withhold the expression of emotions.

With regard to the treatment of the primary respiratory mechanism, the operator works towards the objectives of balancing the craniorhythmic impulse and normalizing cranial nerve function if entrapment is evident. Drainage of the venous sinuses within the dural folds of the cranium is facilitated by treatment of the primary respiratory mechanism. By normalizing the fluctuation of the cerebrospinal fluid, peripheral effects can be achieved throughout the entire musculoskeletal system. Abnormal tension within the intracranial membranes can be released. Restrictions of motion between cranial bones themselves can be improved. One can modify gross structural patterns, for example, the molding seen in newborn infants.⁽⁵⁴⁾

The following are some of the indications for the treatment of the primary respiratory mechanism. Amblyopia,⁽⁵⁵⁾ Bell's palsy⁽⁵⁵⁾ and Tic Douloureux^(56,57) are conditions which may result from entrapment of cranial nerves. Birth trauma^(58,59,60) and whiplash injuries⁽⁶¹⁾ will respond to correction of cranial articular lesions. Tinnitus,⁽⁵⁵⁾ Meniere's disease⁽⁵⁵⁾ and lymphedema⁽⁶²⁾ respond to treatment by decreasing congestion of CSF. Migraine headaches,⁽³⁾ sinusitis,⁽⁶⁴⁾ asthma,⁽⁶⁵⁾ and learning disabilities⁽⁶⁶⁾ all respond to cranial manipulation. Working closely with a dentist the cranial osteopath will benefit those who have temporoman-

dibular joint dysfunction or unusual bite patterns.^(57,68,69,70)

Summary

Pulsation is the in and out of life. Without the pulsatile motion of life, our body does not distinguish itself from the earth's crust from which it is composed, and into which it decomposes, once these pulsations cease. These pulsations enable us to breath, circulate blood, lymph and CSF.

The pulsations of primary and secondary respirations provide every cell of our body with elements of the finest quality, which are fundamental to the sustenance of our electrochemical internal environment. Oxygen from plants joins with our sea water milieu by our expenditure of mechanical energy, pulmonary ventilation. This milieu is further benefitted by the brain's pumping action, by which it creates and circulates the CSF, rich in substances of physiological potency.

As osteopathic physicians, we assist these two mechanisms by facilitating their smooth and balanced functioning. We promote normalization of function through the structure. As functioning of these fundamental mechanisms are maximized, self-healing may result. □

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INTEGRATING OMT INTO THE HOSPITAL SETTING

Laurie Jones

For all its bells and whistles, osteopathy has only two unique distinctions from allopathic medicine.

1. It's holistic philosophy
2. OMT

One could argue that if either or both of those are not visibly evident in deed as well as words, the profession has no right or reason to survive as a distinct entity.

The holistic philosophy leads to common sense medicine, good preventive care, and tends to create, train and nurture General Practitioners - doctors who want to treat and know all of their patients. With the current trend towards preventive care and medicine's sudden fascination with and courtship of the G.P. it might seem that the holistic philosophy itself is enough to keep osteopathy breathing a separate air. Yet holism is a vague and blurry concept, conjuring up everything from mantras and crystals to an entire genre of practitioners who all claim to treat "the whole person."

Holism alone is not strong enough to support a distinct profession. OMT alone is not enough, either. But taken together they made a complete pair - a matching set of principles and practice which entitle a separate group to have a leadership role within medicine today. Yet by abandoning and ignoring the importance of OMT in the health care equation, the profession is much like a child who is weeping, begging for a ride home while sitting on his own ticket.

Unless and until OMT is brought back to the forefront of osteopathic

care, you will continue to see a blurring of rhyme and reason in separating the professions. This is:

- a) Because OMT is the only tangible, visibly demonstratable distinction and;
- b) To ignore it as a treatment modality in favor of invasive or pharmacological solutions is to deny the concept of holism and embrace symptomism - which is a rejection of holism itself.

Either OMT works, or it doesn't.

The rise in demand of manual medicine seems to present a strong case that it does, and if it works, why not use it?

Is it too simple? Too unglamorous? Too time consuming to touch the patient and do a 20 minute check to see if all things are in order?

A recent survey by the American Academy of Osteopathy revealed that while nearly 100% of all patients entering an osteopathic hospital receive a musculoskeletal exam, fewer than 10% receive OMT as treatment. Does this mean that only 10% of the population has osteopathic lesions - 10% of a population who are so afflicted that they require hospitalization?

This calls into question the holistic osteopathic concept. Shouldn't the people going in for surgery or recovering from it have their body's immune system stimulated the most?

DO's are an army marching with no ammunition if they fail to consider or use OMT on their patient. Couldn't we all benefit, in fact, from a regular osteopathic treatment? Then why are the very patients going into osteo-

pathic hospitals being denied a basic level of care?

This is a quality management issue, a moral issue and a medical issue that needs to be addressed. To the one hundred years worth of osteopathic physicians who have fought so hard for the right to give good care and help the body heal itself, not to use and incorporate OMT in the hospital setting reveals a gaping hole in the face of osteopathy itself. □

Laurie Jones is a health care consultant specializing in osteopathic strategic planning and marketing. • The Jones Group • 3330 Second Avenue • San Diego, CA. 92103 (619) 296-6563.



Dr. V.G. Clark-Wismer, a practicing osteopathic physician in Hawaii, attributes her ability to continue with an active thriving practice in part due to her extensive use of the McMannis table. Dr. Clark-Wismer states that the use of the table not only provides controlled traction in re-contouring the back, but also helps the operator maintain the integrity of his/her own back. "More students and physicians should take advantage of the McMannis table in order to prevent injuries while delivering osteopathic manipulative care," states Dr. Clark-Wismer, here demonstrating the use of the table with patient Mary Dempsey.

AAO WORLD REPORT

ROBERT C. CLARK, D.O.

News from around the world of Osteopathy begins with a report from Belgium. M. Renier, the president of the Sutherland Cranial Academy of Belgium, describes the activities of the group. They meet five times a year for "working sessions during which there are 1. a theoretical talk on a topic related directly to the cranial field; 2. a small anatomic review; and 3. practical work." Once a year a full day is scheduled for study with a leading osteopathic practitioner.

He writes that in the past year topics studied were the relationship between the practitioner and the patient; serousitis media; ocular embryology; tissue memory; and kinesiology in the cranial field. The special one day program was study with Viola Frymann, D.O., FAAO on the treatment of fascia in pediatric patients.

For those who wish to contact the Sutherland Cranial Academy of Belgium write the secretary at 108 a, avenue J. & P. carsoel- B- 1180 Bruxelles (Brussels, Belgium).

Next we visit New Zealand where correspondent Robert Bowden, D.O., MNZRO, sends a copy of a 36 page executive summary of a report titled *REGULATION OF NEW ZEALAND OSTEOPATHS A PUBLIC SAFETY ISSUE*. This report documents the reasons why the New Zealand Register of Osteopaths (NZRO) seeks to obtain governmental regulation and licensure of Osteopaths in New Zealand and what the public and professional benefits are expected from this action. As the report states "Anyone, whether well trained or untrained, is entitled to set up practices as an osteopath in New Zealand. ... The NZRO is now urging the government to introduce legislation which will regulate the education, training and ethical standards of osteopaths, to protect the public from incompetent or inappropriate treatment."

Included in the report are case histories of injuries received from individuals practicing as Osteopaths who have had no training or training by correspondence. The degree holding D.O.'s who are members of the NZRO have an enviable safety record and are supported by the New Zealand Medical Association and other health professionals in New Zealand. The ministry of health is providing assistance and supports the NZRO claim that D.O.'s save the country money in the treatment of injury patients through the country's Accident Compensation Commission.

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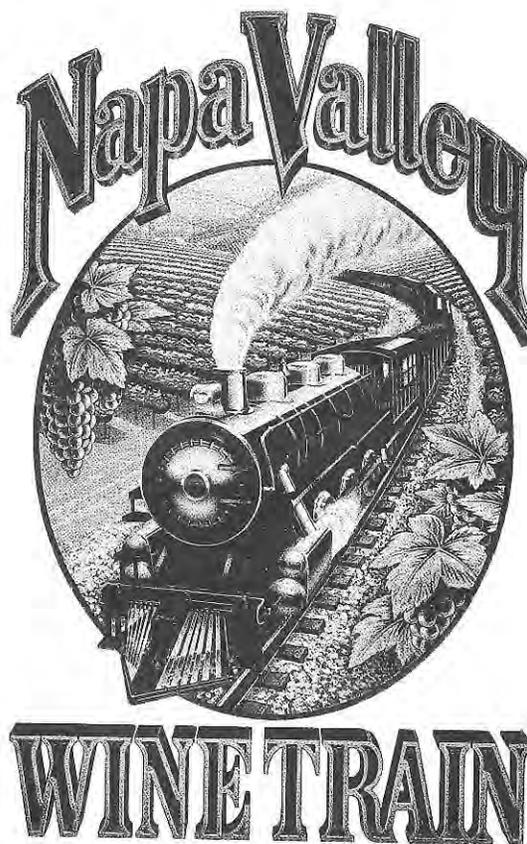
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OBITUARIES

LLOYD W. MOREY, JR., D.O., F.A.A.O

Osteopathic Medicine lost one of its staunchest advocates with the death of Dr. Lloyd W. Morey, Jr., following hospitalization for a serious heart ailment.

Born March 30, 1930 to Lloyd Morey Sr. and Lillian Green in Kirksville, Missouri, and died November 15, 1992 in Milwaukee, Wisconsin at the age of 62. He is survived by his wife Sally, 4047 North 92nd Street, Milwaukee, Wisconsin, 53222; Seven children: Robert Morey, Richard Morey, Ruth (Kay) Olsen, Roger (Marlyse) Morey, Bill Morey (USMC), Barbi Morey, and Robin (Brian) Trenier. One grandchild, Tyler Olsen. Three sisters: Lona Jean (Leo) Reed, Carol (Michael) French, and Sarah (Robert) Marquis. Also nieces, nephews, cousins, other relatives and friends from all over the world.

In addition to his remarkable record of service to the profession, Dr. Morey's career included participation in many national organizations devoted to progress for osteopathic medicine:

Academic: Associate in Science, 1949; Bachelor of Science, 1952; Certified in General Practice, 1973; Certified in Manipulative Osteopathy, 1978; Kirksville College of Osteopathy & Surgery, 1956; Rotating Internship, 1957.

Awards: Fellow in The American College of General Practitioners in Osteopathic Medicine and Surgery, 1967; Fellow American Academy of Osteopathy, 1971; "Honored Patron" Kirksville College of Osteopathic Medicine; "Visiting Clinician AAO.

Past President: Wisconsin Association of Osteopathic Physicians & Surgeons; Wisconsin Society of the American College of General Practitioners in Osteopathic Medicine and Surgery; Milwaukee District Society of Osteopathic Physicians & Surgeons; Cranial Academy; Wisconsin Academy of Osteopathy.

Professional: Who's Who In Wisconsin; Who's Who in the Midwest; Who's Who in the World; President, The Family Medical Center, Ltd., President Positive Communications, Inc.

Memorials have been suggested to the American Academy of Osteopathy, 3500 DePauw Blvd., Suite 1080, Indianapolis, IN, 46268-1136, or Kirksville College of Osteopathic Medicine, 80 W. Jefferson Street, Kirksville, Mo 63501.

-From the Wisconsin Assn. of Osteopathic Physicians & Surgeons, November 1992



Lloyd W. Morey, Jr., D.O., F.A.A.O.

CHARLES A. KNOUSE, D.O.

A resident of Athens, Ohio, Dr. Knouse died August 1, 1993, at age 71. Dr. Knouse retired in 1990 as chairman of the Pathology department at the Ohio University College of Osteopathic Medicine (OU-COM). He also served as director of laboratory services, general clinician and consultant in forensic pathology at the OU-COM Osteopathic Medical Center.

A 1949 graduate of the University of Health Sciences (Kansas City), Dr. Knouse practiced medicine in Howard City (MI), Chicago, Seattle and York (PA). He also previously held positions at the American Osteopathic Association, University Health Sciences and the Kirksville College of Osteopathic College of Osteopathic Medicine.

Dr. Knouse was a consultant in Pathology for the National Board of Examiners for Osteopathic Physicians and Surgeons. A Scott Memorial Lecturer in 1983 Dr. Knouse was a member of the American Academy of Osteopathy, American Osteopathic Association, and The American Medical Writers Association.

A veteran of WWII, having served in both the Merchant Marines and the Army, he was listed in the Who's Who In America World Book.

-From the Ohio Osteopathic Assn.



Charles A. Knouse, D.O.

THE CENTENNIAL CELEBRATION

THE CRIME OF THE CENTURY

John T. Baker, D.O., FAODME

Could it be that the great majority of patients in Osteopathic hospitals do not receive any Osteopathic Manipulative Treatment during their hospital stay?

During the first half of that hundred years almost all of the in-hospital patients were given Osteopathic Manipulative Treatments at least daily, and many received it more frequently, and some even every half hour or so.

Why do we have this marked change in what is considered to be excellent modern therapy?

Also, is excellent modern therapy so wonderful that it cannot be improved upon?

Reasons for the change:

1. Antibiotics came into existence in the early 40's. Penicillin was discovered. Then a bit later sulfanilamide was developed from an earlier substance which had some value. These have since been supplemented and developed into a host of effective antibiotics.
2. Early ambulation was revived in the mid 40's after a long hiatus of 50 years or so since it had been tried in Vienna.
3. Other additions and improvements to the pharmaceuticals slowly improved the care of the acutely ill hospitalized patient.
4. When hospital insurance was developed and became wide spread there was no extra professional, a fee was paid the attending physician. When it

became a reimbursable item it was limited to its use as primary therapy, not an adjunct.

5. Most Osteopathic physicians feel that it takes too much time in their daily visits for the benefit which they feel would be minor.

6. Probably the most important reason is that new postdoctoral trainees seldom see their mentors, or their physicians giving such OMT for other than specific somatic complaints, so they do not learn the advantage, nor do they become inbred with that adjunctive practice. So when they go into their own practice, they usually copy their mentors.

What Can We Do About This?

The first thing to be done is to prove effectiveness, or ineffectiveness of Osteopathic Manipulative Treatment when properly administered to the hospitalized patient with visceral disease. This should prove once and for all whether it is really the "Crime of the Century" or whether "I am all wet".

If it proves the latter, then it can be put to rest once and for all time.

If it proves to be of added benefit, then with appropriate education it can be added to the therapeutic regimes of various diseases for which the patient is hospitalized.

Therefore, in addition to the present excellent program of research aimed at proving the existence of the Osteopathic lesion and that OMT is truly of benefit to lumbar, dorsal, and

cervical somatic dysfunctions, let us develop another research program aimed at proving that OMT is truly of benefit to many diseases of the viscera.

To start, pick an appropriate such disease. I vote for Acute Myocardial Infarction, as much of the writings since 1897 indicate that OMT can influence the circulation of blood through the heart. Hazzard's book of that year made a specific mention.

Then set up a double blind study in willing hospitals that are AOA approved for intern training. Every other admission to the acute care cardiac unit with that diagnosis should be given rib raising of the upper dorsals for two minutes at least on each side and relaxation of the posterior cervical muscles as soon after admission to the Unit as is conveniently possible. This should be done daily or more often if it seems indicated. Orders need to be written. A record is to be kept each time in the progress notes. A recording sheet appropriately designed should be kept current to show progress, or lack of same in preselected parameters such as number of doses of opiates, the same for sedation for arrhythmias, for complications, for length of stay, and for expiration of the patient (such sheets were prepared in 1977 at Saginaw Osteopathic Hospital for such a projected program).

Statistics showed a definite trend early and eventually a definite result.

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PANIC ATTACK- ANOTHER VIEW

Harlan O.L. Wright, D.O.

The basic cause of Panic Attacks, according to the prevalence of orthodox medical opinion today, appears to be that it is a psychological condition brought on by the stresses of living and the patient's inability to cope with them. Hence the recognized treatment is the use of antianxiety agents and counselling by a psychologist or psychiatrist. I believe this postulate to be wrong. While there are admittedly many psychological and stress related factors in the lives of all patients experiencing Panic Attacks, my experience in forty-one years of medical practice and the past twenty years in the nutritional field treating hundreds of such patients, has brought me to the realization that the BASIC CAUSE of Panic Attacks is biochemical and that the observed stress symptoms are only the superficial signs of a much deeper and complicated problem.

The following case history taken from my records is very typical of the numerous cases of Panic Attacks which I have successfully treated over the past two decades since I have been deeply involved in the practice of nutritional medicine. Naturally the patient's name and the dates have been changed to protect privacy but the sequence of the dates remains valid so you can get a good idea of the rapidity with which patients generally respond to nutritional therapy.

Jerry Williams, a resident of another town, had been referred to me by a patient who had similar prob-

lems. He had been suffering with Panic Attacks and a myriad of other symptoms for over two years. He had been treated with the standard method of counselling and Rx's for Xanax and while it had offered little relief for a month or so his symptoms continued to progress in severity until it had gotten to the point where he could no longer perform his job as a salesman. His words to me were "I feel like I am going crazy. I feel there is no cure for my condition. Please help me." I assured him that I had seen many such cases before and that I would try to help him if he would agree to make the necessary changes in his lifestyle that help would involve. He readily agreed.

Jerry's first visit was on February 12, 1990. I had previously studied the comprehensive questionnaire that I have all of my new patients with complicated problems fill out, so I already knew his history and symptoms and had a pretty good idea of his basic problems. His major symptoms were:

1. Fear and explosive rapid heart beat when around people or in an enclosed environment.
2. Severe headaches daily.
3. Trembling and shaky at times during the day.
4. Complete fatigue to the point of exhaustion at times.
5. Mental confusion.
6. Blurry vision at times during the day.
7. Unusual sensitivity to sudden noises.

8. Involuntary weight loss.

9. Chest pains and upper back pains.

10. A feeling of impending insanity.

Previous laboratory workup by other physicians, including CT scan of the brain, blood chemistry, five hour glucose tolerance test, etc. were all normal except for the glucose tolerance test which during the 3rd and 4th hour had dropped into the 50's. However, no serious attention was given to this finding since the orthodox medical opinion seems to be that while high blood sugar is a medical problem, low blood sugar is a non-entity and not worthy of consideration.

Examination revealed an anxious appearing 25 year old male who requested that his examination be conducted in a room close to an outside door so that he could seek escape in case he had a panic attack. Physical findings were essentially non remarkable except for a 2+ gingivitis, moderately fissured tongue several upper rib lesions, several very tender sternocostal junctions and very tender suboccipital triangles and occipital ridges.

Dietary analysis revealed:

Breakfast: Usually nothing but a diet coke. Occasionally an egg and cheese sandwich from What-A-Burger.

Lunch: Hamburger and diet coke. Occasionally a cooked vegetable.

Supper: Hamburger, fries, and a diet coke. Sometimes meat and cooked vegetable.

Snacks: Diet coke (total of five or six daily), chips, peanuts, and corn dogs.
Vitamin supplements: None
Prescription Rx's: Xanax

Diagnosis:

This patient was suffering the severe ravages of:

1. Reactive Hypoglycemia
2. Thoracic and cervical somatic dysfunction.

Treatment:

With the exception of the structural problems which were corrected by three osteopathic manipulative sessions, this patient's myriad symptoms, including the severe panic attacks and tachycardia spells, were due entirely to longstanding malnutrition and its devastating effects.

Treatment:

Jerry was put on a wholesome diet of plenty of fresh foods, with emphasis on salads, fresh fruit, nuts, eggs, whole grain breads and cereals, chicken, fish, and some red meat. He was told to completely eliminate all soda pop and most of the refined flour foods such as white bread, spaghetti, macaroni, etc.

Vitamin supplementation included: A multiple vitamin and mineral tablet with at least 25 mg. of each "B" factor, a tablet containing calcium, magnesium, and zinc, Vitamin C (at least 2000 mg. daily) and Niacinamide 1500 mg. daily. He was also given intravenous infusions of vitamins and minerals on some of his visits, depending on his progress.

On Jerry's second visit on February 26th, most of his original symptoms were either much improved or gone. He had had no headaches for over a week, no more tachycardia spells and his energy was improving. His next visit one month later (March 29th) showed continued improvement and no more tachycardia. At this point we started gradually to reduce

his medication. He was told to return in two months.

He did not come back again until about seven months later. He had gotten off his diet, had been sporadic in taking his vitamins, and had gone back to drinking about two diet cokes a day. Some of the old symptoms, including some of the panic attacks, had recurred. The importance of the diet and vitamins were again emphasized. This time Jerry stuck with the program and continued to improve. On January 3, 1991 he was dismissed as cured, having lost all his panic attacks, fatigue and headaches and now being able to normally perform his work in a satisfactory manner—a complete recovery. This year I got a letter from Jerry's wife, expressing their gratitude and telling me that he was still doing beautifully.

Comments:

It may be of interest for you to know that in my experience patients who have trouble with tachycardia are generally deficient in magnesium. Many times a few I.V. injections of Magnesium Chloride or Magnesium Sulfate will reinstitute normal cardiac rhythm. Most of the time in such cases the serum magnesium level is of little value for it is almost always normal. Nature seems to keep the serum levels of lots of chemicals fairly normal even though there is a cellular deficiency. Also, as so often happens when a patient starts feeling good, they get off their dietary program and think that they are invincible, only to find that their symptoms soon begin to recur. It seems only common sense to me to believe God made the body to operate on certain natural elements found in foods and unless we supply those essentials in the foods we eat the body will eventually pay the price for the deficiencies. I believe that philosophy is well demonstrated in this case. □

*The Centennial Celebration
continued from p. 23*

If and when the trend seems to be positive, this program could be extended to cover a few more conditions, such as the patient who has had abdominal surgery, patients in labor, patients with pneumonia, etc., (I know personally of two post-op patients with paralytic ileus, headed for re-operation, which was aborted with appropriate OMT).

When proven effective there is very little to limit its use in the hospital.

This program of OMT to the patient hospitalized with a visceral problem has a big advantage over the research program on Osteopathic lesions. The latter required Osteopathic physicians who are very adept at lesion diagnosis and the various different types of manipulative treatment. The program I propose is such that any D.O. trainee, or senior student can administer.

So let's encourage this profession of ours to settle this question once and for all time. □

**ENCOURAGE
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1992-93 GOLDEN RAM SOCIETY GROWS

The list of donors to the 1992-1993 Golden Ram Society continues to grow daily. In the December issue of *The AAO Journal*, the Society listed 56 donors with gifts exceeding \$15,350. The list since has grown to 66 contributors who have donated over \$18,900 toward the 1992 goal of \$30,000.

Originally the Golden Ram society supported the 1989 International Symposium. Due to the generous response of Academy members to this appeal, the AAO Trustees and Governors reactivated the Society as an annual fund raising campaign to support the Academy's long range educational goals.

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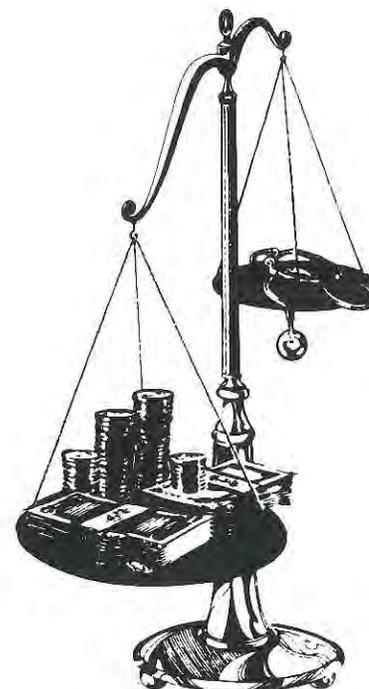
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57. Frymann, *The trauma of birth*, *Osteo. Ann.*, May 1976, pp. 197-205.
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61. Op. Cit., Ref. 11, p. 114-5.
62. Op. Cit., Ref. 11, p. 282.
63. Op. Cit., Ref. 11, p. 289.
64. Op. Cit., Ref. 11, p. 268.
65. Frymann, *Learning difficulties of children viewed in the light of the osteopathic concept*, *JAOA*, Vol. 76, pp. 46-61, September 1976.
66. Lay, *The osteopathic management of temporomandibular joint dysfunction, in clinical management of head, neck and TMJ pain and dysfunction: A multidisciplinary approach to diagnosis and treatment*, edited by Harold Gelb, D.O., W.B. Saunders, 1985.
67. Magoun, *The dental search for a common denominator in cranio-cervical pain and dysfunction*, *JAOA*, vol. 78, pp. 810-815, July 1979.
68. Magoun, *Dental equilibration and osteopathy*, *JAOA*, Vol. 74, pp. 981-990, June 1975.
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continued from p. 21

Dr. Bowden also sends word that similar action is underway in the United Kingdom. An "Osteopaths Bill" was scheduled for a second reading in January. Sentiment of the bill's sponsor was the bill has widespread multi-party support and the second reading was a formality prior to an almost certain passage.

For those interested in the New Zealand report, a copy has been sent to the editor of the Journal. □

CLASSIFIED ADS

UNECOM Residency

OSTEOPATHIC MANIPULATIVE MEDICINE RESIDENCY- AOA approved two year program through the University of New England College of Osteopathic Medicine. Located on the southern Maine coast in an academic setting with ambulatory and hospital based clinical opportunities. Available July, 1993. For further information, please contact Boyd R. Buser, D.O., Chairman, Osteopathic Principles and Practices Department, University of New England College of Osteopathic Medicine, 11 Hills Beach Road, Biddeford, ME 04005; (207) 283-0171 (ext. 330).

D.O. Wanted!

D.O. 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.

Cranial Osteopath Wanted !

Opportunity available for Cranial Osteopath to join an established, OMT-based, holistic group practice in Maryland suburb, north of Washington D.C. Call Osteopathic Associates (301) 587-7072 weekdays.

Associate Wanted!

Associate wanted. Full or part-time. OMT practice. Washington D.C. suburbs. Cranial required. Acupuncture, percussion hammer, homeopathy desirable. Contact Harold Goodman, D.O. (301) 565-2494.

Boston Area:

BOSTON AREA: Seeking one or more physicians to take over a thriving OMT practice. Comfortable office in a small town/suburb just outside Boston. The patients are accustomed to osteopathy in the cranial field, but would welcome any ongoing osteopathic care. If interested contact Dr. Rachel Brooks (617) 646-2320.

UNECOM Assistant/Associate Professor

The University of New England College of Osteopathic Medicine is seeking an osteopathic physician for the position of Assistant/Associate Professor of General Practice/Osteopathic Principles and Practices. This full-time position will balance responsibilities between academic duties in the Department of OP&P and patient care in the University Health Service's facilities. Academic duties will consist primarily of lecturing and course oversight in Osteopathic Principles and Practices as well as Physical Diagnosis and Family Medicine. The successful candidate will be an osteopathic family practitioner with special interest and qualifications in the practice and teaching of OP&P including training in indirect and direct manipulative modalities. Certification in OMM or family practice and instructional experience are desired but not required. The level of appointment and tenure track possibilities depend on experience. The University of New England offers a competitive salary and benefits. For consideration, please forward a resume or C.V. with cover letter to the Director of Human Resources, University of New England, 11 Hills Beach Rd., Biddeford, ME 04005. UNE is an Equal Opportunity/Affirmative Action Employer.

NEW BOOK OFFERINGS FROM THE ACADEMY

The American Academy of Osteopathy is pleased to announce three new books which are now available from the Academy! Each sells for \$34.95 plus postage/handling and discounts do not apply. Call the AAO to place your order (317) 879-1881.

Osteopathy: Research and Practice by A.T. Still

This influential book is the last work of A.T. Still, the founder of Osteopathy, whose ideas have greatly influenced the practice of all forms of manual medicine.

In his final exposition of osteopathic fundamentals, the author summarizes his vision of health and disease. He then looks at each region of the body and describes how he himself would approach the diagnosis and treatment of specific diseases.

A new introduction by Harold Goodman, D.O. provides historical background and sets this book in the context of the 'old doctor's' other writings. Long out of print, this new hardbound edition is required reading for all practitioners of manual medicine.

Andrew Taylor Still - 1828-1917 by Carol Trowbridge



WE HONOR
BOTH



This volume is the first biography of A.T. Still published in the past 50 years and its publication coincided with the 100th anniversary of the first school of Osteopathy. Carol Trowbridge, the author has carefully researched Still's life by scrutinizing hundreds of letters and other materials in Still's handwriting plus hundreds of documents of that time. From this has come a biography that reveals new and important facts of Still's life.

Trowbridge places Still firmly in the dynamic intellectual and medical developments of the late nineteenth and early twentieth centuries. Still emerges as a physician who was not only on the cutting edge of medicine but also was a medical pioneer in the founding of Osteopathy. The eminent medical historian, John Ellis of Lehigh University, says that this biography "makes an important and significant contribution to the history of American medicine."

Frontier Doctor, Medical Pioneer by Charles E. Still, Jr., D.O.

This is the story of the founding of Osteopathy involving three generations of the Still family. It is a charmingly told story of this first family of Osteopathy based upon extensive notes and documents first collected by Charles Edward Still, Sr. 60 years ago and the recent careful research of his son, the author of this book.

"This is a most timely book as the Osteopathic profession prepares for its second century. Having, in its first century, achieved such enormous success, it would be well for the profession, including its students, to recall its humble and heroic beginnings. It would do well to remember the noble purpose for which it came into existence, that of basing the practice of medicine on the patient's own inherent healing powers and support."

Irvin M. Korr, Ph.D.
Emeritus Professor at Kirksville College of Osteopathic Medicine
and Texas College of Osteopathic Medicine

AAO Speakers Bureau Profile

The American Academy of Osteopathy invites its members to submit their names for consideration as speakers, willing to offer their expertise in teaching osteopathic manipulative medicine at seminars, workshops and conventions. The AAO frequently gets requests from state/local osteopathic associations, hospitals and physician groups to recommend lecturers in OMM. The Academy will compile responses from this survey to develop a pool of candidates for referral to requesting organizations. The individual sponsors will contact the AAO member directly.

Name	School	Yr/Grad
Office Address	Home Address	
() Office Telephone	() Home Telephone	

List your areas of expertise on which you would be willing to prepare a presentation or workshop to teach fellow osteopathic physicians. Also list your experience in delivering such presentations. For example: Myofascial release/Unwinding — two hour lecture/workshop conducted at Smith Osteopathic Hospital in July 1992.

(1) Topic/Technique: _____

(2) Topic/Technique: _____

(3) Topic/Technique: _____

In the past, have you been sponsored by a pharmaceutical company, medical equipment vendor or other corporate organization? _____ If so, please list the sponsor: _____

Please return a completed copy of this form and a current copy of your Curriculum Vitae to:

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

CALENDAR OF EVENTS

March 1993

March 4-7 **AOCPM**

American Osteopathic College of Preventive Medicine Midyear Conference
Contact : AOCPM, (404) 953-1803

March 4-7 **Florida**

Florida Osteopathic Medical Association Annual Convention Doral Ocean Beach Resort, Miami Beach, FL Contact: Stephen Winn, (904) 878-7364

March 6-7 **AAO Long Range Planning Committee**

AAO Headquarters in Indianapolis

March 12-1 **Pathologists**

American Osteopathic College of Pathologists Mid-year Tutorial - San Antonio, TX Contact: Joan Gross, (305) 432-9640

March 13-18 **OB/GYN**

American College of Obstetricians and Gynecologists Annual Convention, Dorado, Puerto Rico
Contact: Barbara Hawkes, (313) 332-6360

March 17-21 **ACGP**

ACGP Annual Convention - Orlando, FL Contact: George A. Nyhart, (800) 323-0794

March 19-21 **Anesthesiologists**

American Osteopathic College of Anesthesiologists Mid-year Seminar Chicago Contact: Bert M. Bez, D.O., (816) 373-4700

March 22 **AAO Board of Trustees Meeting**

THE GRAND Kempinski Dallas, TX

March 23 **AAO Board of Governors Meeting**

THE GRAND Kempinski Dallas, TX

March 23 **AOBSPOMM Examinations**

THE GRAND Kempinski Dallas, TX

March 24-27 **AAO Convocation**

THE GRAND Kempinski Dallas, TX

March 27 **AAO Board of Trustees Meeting**

THE GRAND Kempinski Dallas, TX

March 27-31 **AOA Board of Trustees**

American Osteopathic Assn Annual Mid-year Meeting of the Board of Trustees-Palm Springs

April 1993

April 1-5 **Dermatology**

American Osteopathic College of Dermatology Mid-year Conference- Vail, CO Contact: AOCD, (404)953-0802

April 20-24 **Arizona**

Arizona Osteopathic Medical Association Annual Convention-Crescent Hotel and Conference Center, Phoenix, AZ Contact: H. Ted Podleski, (602) 840-0460

April 22-25 **Tennessee**

Tennessee Osteopathic Medical Assn Conven. Gatlinburg, TN. Contact: TOMA, (404) 955-5538

April 22-25 **West Virginia**

West Virginia Society of Osteopathic Medicine Annual Spring Conv. Huntington, WV Contact: Charlotte Pulliam, (304) 345-9836

April 29-May 2 **Rhode Island/Yankee**

Rhode Island Society of Osteopathic Physicians and Surgeons Annual Yankee Osteopathic Medical Conf. Goat Island, RI Contact: Dorothy Blackwell, (401) 781-3940

April 30-May 1 **AAO**

American Osteopathic Academy of Orthopedics Mid-Year Meeting - Scottsdale, AZ

May 1993

May 2-5 **Healthcare Executives/ AODME**

College of Osteopathic Healthcare Executives and Assn. of Osteopathic Directors of Medical Education - Clearwater, FL Contact: David L. Kushner, (202) 686-1700

May 13-15 **Texas**

Texas Osteopathic Medical Association Annual Convention- Austin, TX. Contact: Terry Boucher (800) 444-8662

May 19-23 **Pediatricians**

American College of Osteopathic Pediatricians Annual Convention. Contact: Theresa E. Goeke, (609) 393-3350

May 20-23 **Radiologists**

American Osteopathic College of Radiology Mid-year Conference, Kiawah, SC Contact: Mark S. Finkelstein, D.O., (800) 258-2627

May 21-26 **Sutherland Cranial Teaching Foundation**

Basic course, 40 hour 1-A CME, Chicago. Contact: Judy Staser, (817)735-2498

May 24-28 **Intermediate Cranial Course**

"The Expanding Osteopathic Concept: Intermediate Cranial Course"- Director: Viola Frymann, D.O., FAAO, Pomona, CA 40 hours CME 1-A CME. Contact: Jane Riplog, COMP (800) 447-2667 ext. 5385

May 28-30 **The National Osteopathic Women Physicians Association**

N.O.W.P.A. will be presenting "The Women Physicians Leadership Retreat". "The Power of I AM", Tucson, AZ. Contact: Judith Lewis, D.O. (206) 528-5845

June 1993

June 2 **Connecticut**

Connecticut Osteopathic Medical Society Annual Convention Contact: Nicholas J. Palermo, D.O., President, 225 Main St., Manchester, CT 06040

June 19-23 **Cranial Academy 40-hour Basic Course**

"Osteopathy in the Cranial Field"- Burlington, VT. Tuition: \$1,000. Contact: CA office (317) 879-0713.

June 24 **Competency Examination Cranial Academy Board Meeting.**

June 25-27 **Cranial Academy Conference**

"Primary Respiration" Featuring Anne Wales, DO and Frank Willard, PhD. Directors: Drs. Gintis and Ettlinger. Contact: CA office, (317) 879-0713.

June 24-27 **Colorado**

Colorado Society of Osteopathic Medicine Annual meeting. Primary care updates on orthopedics, gynecology, pediatrics and more. 18 hours 1-A CME. Contact: Patricia Morales, (303) 322-1752

THE MARCHEL IVERY QUARTET/QUINTET



**Time to
Jazz Things Up
a Little**

This year after the Annual Awards Banquet at Convocation, stay tuned for the best of jazz entertainment brought to you by the **Marchel Ivery Quartet/Quintet**. Marchel, an extraordinary Texas reedman, has played with the likes of Bud Powell (in France), Art Blakey and the Jazz Messengers (in New York), Red Garland (also a Dallas resident), Hank Crawford, and David "Fathead" Newman (best known for his stints with the Ray Charles band.) Marchel's rich sax tone and improvisatory power "blow" that of any other sax master.

Tickets are only **\$5.00** apiece. Purchase in advance from the Academy office or buy them at the door. There will be a **cash bar and dancing**.

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