# Thomas L. Northup Lecture—1983 American Academy of Osteopathy: AAO—Yesterday, today and tomorrow

JOHN P. GOODRIDGE, D.O., FAAO
East Lansing, Michigan

*Thomas L. Northup, D.O., for whom this lecture is named, died in October 1982.*

Years ago the Academy had many members it wished to recognize in one form or another. One way was to ask the individual to present the Academy Lecture at the annual meeting. Thomas L. Northup, D.O., was so honored and presented one of those lectures. But the Academy Lecture almost didn't become the Thomas L. Northup Lecture. Dr. Northup lived years beyond many of his luminous contemporaries. As a member of the Board of Trustees of the Academy, I recall the requests following the deaths of several of our illustrious members that the Academy Lecture be named for them. Since Thomas L. Northup was the prime mover of the organization that now bears the name of the American Academy of Osteopathy, and since his office served as the legal residence of the corporation until it moved to Colorado in 1972, and since he served as secretary for its first 10 years and as editor for its first 7 years, it seemed that if the Academy Lecture was to be given the name of any of its members, it should be named the Thomas L. Northup Lecture. Therefore, at their 1972 annual meetings, the Board of Trustees and the Board of Governors voted that the Academy Lecture be named the Thomas L. Northup Lecture.

In 1937, Dr. Northup and sixty-five of his colleagues petitioned the American Osteopathic Association for a section of the annual convention program to focus on osteopathic structural diagnosis and manipulative therapy.[1] The request was granted and in 1938 the section began. The same year the Osteopathic and Manipulative Therapeutic and Clinical Research Association was organized to support the sections program. That association has become the American Academy of Osteopathy. Its stated objective was "the development of manipulative therapy and it's application to human pathology due to structural disturbances as well as the promotion of programs that stress the fundamental principles of osteopathy."[2] In the rest of this presentation I will focus on two things which I think are compatible with the objective originally stated by Dr. Northup's group. First, I will repeat what another has said, that the uniqueness of the osteopathic physician is his/her ability to feel the inherent motility of the patient. Second, I will suggest a strategy for the Academy to follow so that our practitioners possess this skill.

What are the facts that lead me to the conclusion that feeling the inherent motility is the uniqueness of this profession? Forty years of practice have shown me that this is what is left if this profession is to remain unique and separate. I will also review some of my history, which probably isn't much different than yours, but which may cause you to focus on some of your experiences and have you come to my conclusions.

I recall while a student at the Kirksville College of Osteopathic Medicine my sense of ineptitude as a manipulator. I joined several of my classmates and paid a recent graduate, a son of a chiropractor, to teach us manipulative techniques in ten weekly sessions in his office and received an album of photographs picturing the techniques. As an intern in an osteopathic hospital, I learned some specific soft-tissue procedures for pre- and post-surgical cases and patients with pneumonia who, according to the classification of the day, should have succumbed, but didn't.

I entered practice in the office of a D.O. who was categorized as a strong manipulator. Sometimes he was too strong, and I was delegated to make the housecall the next morning when the patient could not get out of bed. I learned to titrate the dosage for manipulation.

I was fortunate to be included in the group of D.O.s in New England who palpated for localized tissue response to the operator's specifically conducted movement of regions or segments of the body. The movements identified were flexion, extension, rotation, and sidebending. Johnston has since expanded those four and added inhalation, exhalation, and translation into four quadrants as well as in the coronal and sagital planes. With testing for ease and bind, we searched for a state we called "dynamic neutral," a term which was abandoned because it promoted more debate than understanding (more heat than light). However, I

think it is akin to what the cranial group refers to as the "stillpoint" and what Jones calls "mobile point." This testing directed me to focus on response to demand and enabled me to be more specific with my manipulation procedures. While at first the procedure took longer than thrusting and gapping, the patient's problem required fewer repeat visits and less discomfort following treatments. In fact, the patient, at first thinking they hadn't been treated, perceived increasing comfort over several hours after the treatment.

About this time I attended several courses on the cranial concept. These courses emphasized the osseous anatomy and membranes within and about the cranium but omitted palpation for the cranial rhythmic impulse. I believe this was omitted, because it could not be made visible by photography.

During this interval I attended a program at the New York Academy of Osteopathy when Dr. William Nicholl[3] presented a 50-year review of manipulation. Dr. Nicholl was a student at the Kirksville College when Dr. Andrew Taylor Still would drop in on the classes from time to time and would work with students in the clinics. Dr. Nicholl said that the type of technique that Dr. Still used was not of the thrusting force or popping type of technique taught in the classroom. Dr. Nicholl's statement in New York reminded me of a fraternity house technique session when I served as the patient for Dr. Charlie Still, son of A. T. Still. As he manipulated or mobilized my thoracic cage and thoracic spine, he said, "this is how my father treated." To me it was like what I now call articulatory treatment, but he may have included some still points. Dr. Charlie added he didn't know how the "popping," which was so prevalent at that time, got started; however, his father did not use it.[4]

Perhaps the popping got started in Davenport, Iowa. Hildreth,[5] who described Palmer's visit to Kirksville in 1893, wrote that he first saw the Palmer (chiropractic) method of manipulation demonstrated by C.E. Achorn at the 1900 AOA Convention. Hildreth described the technique as "a very crude and a very poor imitation of the kind of manipulation therapy Dr. Still practiced."

I believe at this point it is interesting to note two items. First, the March 1982 issue of *Health* magazine published by the AMA stated "a recent breakthrough in chiropractic might finally nudge the practice into medical respectability: a diagnostic procedure called 'motion palpation.' "[6] It was reported to have been developed by a Belgian chiropractor and brought to the U.S. by way of Ottawa, Canada. The second item is a letter received by the Academy in 1981, from a chiropractor requesting copies of articles in the *Academy Yearbook*. The chiropractor wrote: "I would like to learn more about what Lippincott describes, what Sutherland describes, what Frymann describes, as this cranial treatment. . . I know we can make a fast buck doing things in a hurry with popping, etc., but if I really want to be more effective, I've learned there is another way, and I want to learn more about it."[7]

At the 1968 AOA Convention I was the subject for a demonstration of techniques. As the subject I perceived a tightening response which correlated exactly with what the operator was telling the audience, but which they at their distance could not feel (well, maybe some of them could; but if I were among them I wouldn't have). I have confidence in the operator's palpation. He used a therapeutic approach new to me. This experience plus others lead me in 1970 to join what I thought was the first Academy sponsored tutorial. I say "thought" because on reading the writings of Dr. Northup I see that early in the organization of the Academy, Dr. Northup and members of the Board of Governors would seek out members of the profession and spend time on a one-to-six ratio to study and become familiar with their procedures. That one-to-six ratio today is used for the Academy programs called tutorials. At that 1970 tutorial we learned the tutor's diagnostic routine and treatment procedures on patients with presenting complaints. On the last day we were tested and supervised on diagnostic and therapeutic procedures on additional patients we had not seen before, patients who had presenting complaints. This gave us the confidence to return to our offices and use the procedures. While I thought of the therapeutic procedures, as "patient's active cooperation procedures," they became popularized as "muscle energy procedures." I found one procedure to be very effective. It was the one used for what was called a sacral torsion. For my purposes sacral torsion is defined as that constellation of findings which can be resolved with the patient in one position by one maneuver on the part of the operator. Prior to this, for the findings present, I would have used several positions and had the patient assume several positions. This and some of the diagnostic procedures learned at that tutorial became time savers for me. By this time I had a variety, or spectrum, of manipulative approaches to use for my patients and my "success" had increased my confidence.

My next step was to join the faculty of an osteopathic medical school. Now I was really a student and also an observer. I attended cranial courses

sponsored by the Sutherland Foundation emphasizing the cranial rhythmic impulse. I understand and accept the concept, but my perception leaves much to be desired. I have attended courses on "counterstrain," and when I search for and find a tender point, I can usually relieve it.

I have observed at the Michigan State University—College of Osteopathic Medicine, a variety of manipulative approaches among my colleagues; some I have not seen before. One colleague talked of fields of energy; he also appeared to have some sense akin to clairvoyance. While I do not understand what he perceives, I have the inherent feeling there is substance to what he does. At one point my department chairman, a Ph.D., asked me what I thought of cranial osteopathy and I replied, "I think it is the cutting edge of osteopathic medicine."

As a teacher I needed answers for the questions students did and would raise; answers that were mine and not repetitious of someone else's words. The Sutherland lecture of 1981 by Dr. Edna Lay,[8] whose credibility I have judged as superior, was a beginning. She talked of the subtle energies functioning in nature, as cited by physicist William A. Tiller, and she correlated these statements with the statements made by Sutherland. The next year Dr. Eschtruth[9] in her Sutherland Memorial Lecture spoke of the vital life forces.

In March 1983 the Academy convocation on the subject of palpation and touch included many interesting presentations. Then when the Cranial Academy Newsletter[10] announced a seminar on the subject of life's forces and I applied, I learned it was oversubscribed and I would have to wait until another time. I've learned that this seminar dealt with the use of the hands to detect in a certain manner tensions which by manual procedures can be released and have wide-ranging manifestations. I am still on the waiting list, or in a stand-by position, for inclusion at a subsequent seminar.

In the past year I have served on a task force committee to deal with the integration of osteopathic principles throughout the predoctoral curriculum. The committee is composed of D.O. clinicians, Ph.D. scientists in the basic sciences, Ph.D. educators, and an M.D. psychiatrist. At the outset we D.O.s were told that the osteopathic profession did not have an exclusive on the principles it called osteopathic principles. We then changed our language to talk about what the D.O. emphasizes in his practice and teaching more than or different than the M.D. A review of a survey made a few years ago among clinical faculty identified two issues of emphasis: one was emphasis on the whole person, on holistic health, and the other was the teaching and use of manipulation. The M.D. psychiatrist challenged our exclusiveness in the area of holistic medicine.

This was a valid challenge. There are ninety-two English titles listed under "Holistic Health" in the 1980-82 issues of *Cumulated Index Medicus* and only two are by a D.O. Those two are Dr. George Northup's two editorials about the holistic health movement. In 1978 Leslie J. Kaslof[11] compiled and edited *Wholistic Dimensions in Healing* with contributions from over fifty authorities in the field, only two of whom were D.O.s. It is a resource guide the purpose of which is "to supply a much needed resource tool for both the lay public and the practitioner, by indicating where there is interest and receptivity among professionals to implement new ideas within their respective fields." In 1980 Hastings, Fadiman, and Gordon[12] edited *Health for the Whole Person: The Complete Guide to Holistic Medicine,* based on a report for the U.S. Government prepared by the Institute of Noetic Sciences, San Francisco, California, for the National Institute of Mental Health. In 1980 Patricia Flynn[13] published *Holistic Health: The Art and Science of Care*, a textbook for nurses and other health care practitioners. In 1982 Phyllis Mattson[14] published *Holistic Health In Perspective*, a book "which described holistic health principles, practice, personnel, programs, and problem. . .essentially an overview for a new movement." Each of the last 2 had 10-page bibliographies. These are only a few of the publications in recent years.

In 1967, I stated that hopefully D.O.s would manage the health care of the whole person, but that it was conceivable that this might be by social workers or the clergy.[15] In 1970 Granger Westberg, professor of practical theology at Wittenberg University, and volunteering physicians opened a clinic in the parish house of a church in Springfield, Ohio, to test and serve the spiritual component of health care. This experiment has grown into what is now known as Wholistic Health Centers, Inc.

"Wholistic health care (in these centers) is based on the metaphysical affirmation of body, mind and spirit integrated in a whole, independent of and greater than the sum of its parts. In practice, wholistic care means actively searching with people all dimensions of their lives (physical, emotional, intellectual, spiritual, interpersonal) for causes and symptoms of disease, then creatively exploring these same aspects for treatment strategies to restore or maintain health."[16]

The Wholistic Health Center is a church-based family practice medical care facility that utilizes an interdisciplinary team of physicians, pastoral

counselors, and nurses who focus on all aspects of the individual's health needs. The centers are programmed to fit within the mainstream of medicine in that the counselor follows the patient in and out of the hospital when necessary, and specialists communicate with the attending physician in the center. Patients are followed annually to keep abreast of their state of health. The centers receive support from the University of Illinois Medical School in Chicago and the Kellogg Foundation of Battle Creek, Michigan.

Today there are eleven of these centers, but the goal of the corporation is not to increase the number of its centers, but to have existing health care centers modify their operation toward the model for the Wholistic Health Center.

From my view as an osteopathic physician, as appealing as these centers are, they still lack the searching hands of the D.O.

Since we have been told that the osteopathic profession does not have an exclusive on what it calls osteopathic principles or on holistic health, what about manipulation?

In the 1955 A.T. Still Memorial Address, Dr. Thomas Northup stated, "The osteopathic approach to the understanding of disease and its management is different from that of old school medicine. The principal difference is the ability to detect structural disturbances before the associated pathologic processes have become organized and irreversible. Increasing attention to body unity and to the physiologic character of disease by all schools of medicine has, however, lessened the degree of difference."[17]

Does the profession have an exclusive on manipulation?

For the years 1979-82 inclusive, the *Cumulative Index Medicus* has listed 62 articles on manipulation published in English—eight of which were by D.O. authors.

In 1960, Licht[18] edited a book entitled *Massage, Manipulation and Traction.* In 1980, Basmajian[19] wrote in the foreward to the second edition now named *Manipulation, Traction and Massage* that "the order of topics is changed in the title to reflect the changing emphasis of modern times." He further stated that "A major contribution of this new edition is its great emphasis on manipulation," which was written by Robert Maigne, M.D. It is my understanding that Dr. Maigne learned his manipulative procedures from Myron C. Beal, D.O., when Dr. Beal was teaching at the London College of Osteopathy. In the August 1982 issue of the *American Journal of Physical Medicine*, Kewalramani[20] reported on three cases of myelopathy following injudicious use of cervical spine manipulation but also stated that judicious use of non-forceful mobilization/manipulation deserves a place in the therapeutic armamentarium.

At about that time, I was entertaining the thought that perhaps there was no reason for two separate complete schools of medicine other than the reasoning that there ought to be two airlines or two telephone companies providing essentially the same service so the public might benefit from the competition.

Then informally, in the aisles of the American Academy of Osteopathy's Convocation in Colorado Springs in March 1983, because I had a question and I was listening, I heard Dr. Frymann say the uniqueness of the osteopathic profession is the D.O.'s ability to feel the inherent motility of the patient. Dr. Thomas Northup was described by his son as "a promoter of people other than himself. . . He was a gentle persuader and helped bring many important people to the attention of the profession."[21] Dr. Frymann has been one of those important people and in her 1977 Thomas L. Northup Lecture she said, "it is to Dr. Northup that I owe my osteopathic career. I was a disillusioned student, bitterly disappointed and discouraged because I could not find the osteopathy that I had come to America to learn, when Dr. Northup threw me a lifeline and urged me to delve into the early literature in order to enter the AAO essay contest on the role of the osteopathic lesion in the production of cardiac pathology. I discovered a gold mine of osteopathic experience. The following year he encouraged me to enter again, this time researching the role of the osteopathic lesion in functional organic renal pathology. A year later I had just opened my office when he sent me a personal invitation to attend the first course in basic mechanics to be taught by the Academy of Applied Osteopathy in Los Angeles. At last, I was on my way. Thank you, Dr. Tom, for your faith and confidence in those dark days, for showing me 'the small light in the horizon of truth' as seen by A.T. Still in 1874."[22]

Soon after the convocation I had an informal conversation with the anatomist member of our task force for integration. I told him of the concept of sensing the inherent motility of the body. I don't recall what I said but he replied that he had learned more about osteopathy in that last five minutes than he had learned in all of the previous meetings of the task force.

The inherent motility to which I think Dr. Frymann refers is the rhythmic motion perceived over any part of the body attributed by Sutherland to the coiling and uncoiling of the brain and its effect upon a fluctuation of the cerebrospinal fluid and

the connective tissue of the body primarily through the reciprocal tension mechanism of the dural membranes. As D.O.s studied with Dr. Sutherland, their thoughts focused on the cranium and it was some time later that they realized the cranium was attached to the body. They then became aware that what they sensed at the cranium could also be perceived elsewhere in the body. In the words of Dr. Frymann, "the human being is a dynamic unit of function each part integrated with every other by the inelastic living membrane, the fascia. The sensitive discriminating hands on the head may detect impediments to physiologic function in some remote part of the body. Conversely, cranial strains may be diagnosed by diagnostic palpation of other regions. The inherent physiologic motion of the primary respiratory mechanism has been distorted, impaired, reduced, increased, or changed in its pattern. No matter where the primary cause may lie, the effect will quickly be detectable throughout."[23]

She has written that emotional stress[24] or physical traumatic stress[23] is felt as force traveling in only one direction, an outgoing direction, through the body; it does not have the to and fro character of other forces. Becker[26] has written that sensing these forces may reveal the historical onset, acute or chronic character of a problem, and the prognostic potential for the patient's recovery.

A good many D.O. internists think of manipulation as only "thrust, crunch, pop" and therefore declare it contraindicated for their patients. But even the best internist must at times wonder why some of his patients respond to what he prescribes and others do not. An osteopathic internist who has the ability to perceive his patient's inherent motility might be able to distinguish between the patient who will respond and the patient who will not.[27] And if he himself has not developed the skill to alter that inherent motility toward health, he would at least know it was necessary to be done and he could bring to his patient some other D.O. who had perfected that skill.

To perceive this motion, Dr. Frymann has written that one "must jump on and become attuned to the inherent momentum of the body, ride with it and become a part of it," as jumping aboard a moving street car.[25] (I have trouble visualizing Dr. Frymann running along the side of a San Francisco cable car to board it while it is moving, but she certainly seems to know what it feels like.)

The fact that this concept is effective is attested to by numerous case histories in the osteopathic literature.[28-32] Dr. Frymann described how a single treatment which permitted the spontaneous unwinding of the body with the patient in the seated position allowed a patient to return to work in a few days leaving a few individual somatic dysfunctions to be attended to later.[33] This suggests that there is something deeper, something more primary than individual somatic dysfunction that must be functioning appropriately. I can think of four physically traumatic accident cases with undoubtedly some psychologic overlay with whom I have been unsuccessful dealing only with individual somatic dysfunctions and for which I ought to be able to be more effective when I can work with the total body inherent motility.

This skill, possessed by probably fewer than 200 D.O.s, needs to be learned by all D.O.s if this is what makes us unique. Some might consider it "far out," but "far out" is one of the descriptors of unique. I say fewer than 200 because there are about 200 regular members of the Cranial Academy, some of whom do not have this skill, but I assume all who have this skill belong to the Cranial Academy. I say all D.O.s and call your attention to what Allen wrote in 1964 "since we cannot compel others to judge us by virtue of the work of our most 'skillful practitioners only, it behooves each of us for that reason and for the sake of better daily service to our patients unceasingly to 'Improve Our Skills.' "[34]

As I say this I have not forgotten the admonition of Dr. George Northup that "manipulative therapy makes clinical sense only when it is integrated into the practice of comprehensive medicine,"[35] nor MacBain's advise that "if manipulative measures are to be generally useful and accepted, the two disciplines (internal medicine and manipulation) need to be combined."[36] Graduates of colleges of osteopathic medicine are well versed in internal medicine and the opportunities for continuing medical education in internal medicine are unending, but the opportunities for increasing one's skills in diagnostic touch and manipulation need to be increased in numbers and in efficiency.

Those proficient with this skill got their foot in the Academy's door at the 1983 convocation. Now the Academy needs to open the door wide and recruit teachers from the Sutherland Cranial Foundation, the Cranial Academy, and some professional educators to develop tutorials in a step fashion so that each student may advance at his own rate with curriculum geared to attainment and doing more in less time.

I recall the step method when I learned how to ski. We demonstrated our ability before each class began and we were directed to the step, or stage, the most homogeneous group with or within which we would most aptly advance our skill. I recognized that even at the same level, instructors var-

ied in their verbal help for me to improve. I seemed to spend an eternity at the "stem turn" level until one day an instructor advised me to put my hand behind my knee. I had not heard that cue before. That made the difference; from then on I advanced.

I believe the step method includes the categories of prerequisites, advance organizers, discovery, positive reinforcement, evaluation, constructive criticism, separation of fact from theory, criteria for advancement, and feedback among instructors of problems experienced in communications of ideas or skills with students and of innovative procedures tried to resolve the problems. Skills to be mastered need to be stated in writing. Exercises to practice to master those skills need to be clearly described. Questions students should ask of their diagnostic touching should be in writing. (Examples of these may be found in the writings of Frymann and Becker.) Students should be at liberty to use their own descriptors to relate what they perceive—not what they think their instructor wants to hear. Some of the prerequisites to be determined before admission to such a tutorial are as follows: What didactic anatomy and physiology must an applicant have had? What anatomic information and physiologic processes must an applicant know at the present time? What minimum skills of perception are required at the present time? Must one have the ability to perceive the manifestation of thoracoabdominal respiration at the chest, at the head, at the lower extremities? Must one have the ability to identify by palpating the head when the patient flexes and extends the big toe, and on which side? Must one have more than these, or less than these? Must the registrant believe before entering the tutorial that he can learn to feel the inherent motility of the body? Must the applicant consent to practice exercises prescribed and consent to being evaluated on his ability and increasing ability to perceive the inherent motility of the patient?

Advance organizers is a phrase most easily understood by the instructor planning a period of instruction. First, if the student is not already familiar with the terminology, the instructor must define the new terms as they are used or provide a glossary before the instructional period. Similarly if the student is not familiar with known and accepted anatomic concepts or physiologic processes, the instructor must prepare the student (in advance) before moving on. Prerequisites are examples of but not all inclusive of advance organizers. Some instructors assume their students know more than they do and soon run too far ahead of the students. Asking the students questions to find out where they are on the path to learning new skills saves time in the long run, and encouraging the student to ask the instructor questions often brings out the prime question leading to the instructor's next point.

When presenting new concepts (theories), it is more effective to set the scene for the student to experience or discover some facts before offering an explanation for the facts. Ask the student palpating a rhythm of the body if the impulse continues after the patient holds his breath? If the impulse continues and if the student thought the impulse was due to the thoracodiaphragmatic movement, he is now ready for another explanation. If he is told there is a movement which he can feel when the diaphragm rests, his fixed concept about respiration may interfere with his perception. Discovery is an excellent way to melt away fixed concepts.

I recall two experiences with students who testified they could not feel bone through the skin and overlying soft tissue. One student said no way could he accept that he could feel the transverse process of the atlas bone. I asked him to press his finger medially between the mandible and the mastoid process of the temporal bone and asked him to describe what he felt. He said he felt something hard. I suggested we imaginatively dissect away the skin he had contacted, then the superficial fascia and fat, now I asked what do you see that might be the hardness you felt. His answer, "the transverse process of the atlas."

The other student agreed he could feel the spinous process of the lumbar vertebrae but he couldn't accept the projection of his perception to feel the lumbar transverse processes. This fixed concept persisted when we were palpating the patient's cuboid bone. I picked up the skeleton of a foot and showed him the tubercle on the plantar surface of the cuboid and the lateral angulation of the surface and asked him to compress his thumb into the plantar surface of the foot to see if he could trace with his thumb the tubercle and the lateral angulation, and he did. I know he did because the Ford lightbulb you have all seen in the Ford TV ads lit up on his face. He had discovered the cuboid, a bone in a patient's foot. When he appeared for his practical examination his palpatory assessment of his subject was excellent in view of the criteria established at that time.

I like these experiences more than the one in a practical examination where the student trying to answer a question looked up to the ceiling and said, "I can see it in the book, it comes several pages before the thrusting procedure for the lumbar spine, but I can't remember it." That student discovered that memorization is not the way to

pass a practical examination, This reminds me of the instructor who stated, "the students should know it because I told them on such and such a date." I am glad to know I have company with others who do not hear everything that is said in a 50-minute lecture.

Not until I became a teacher was I aware of the necessity for positive reinforcement. I wasn't in the habit of telling my patients of all the parts that worked well. I focused on what wasn't working well. As they improved, I focused on what needed more improvement. The experience that sold me on the need for reinforcement occurred on the ski slope. As I was riding the chair lift, I observed a member of a ski class performing a traverse and heard the instructor tell him it was "great." How could the instructor say that? The man's downhill ski was ahead of the uphill ski (wrong), his downhill knee was extended (wrong), his weight was on his uphill ski (wrong), his shoulders were facing uphill (wrong), but he traversed the slope without falling; great! Now the student was ready to try it again, and this time he would focus on the instructor's constructive suggestions about the proper positioning for skis, knees, and shoulders.

I now make a positive complimentary comment to the student before I offer a constructive suggestion.

We physicians receive positive reinforcement when our patient begins to feel and function better. We physicians, as students, need positive reinforcement that the skill we are trying to learn will be an addition to or better than the skills we already possess. One area in the skill to perceive inherent motility that needs positive reinforcement of more than an instructor's verbal assurance is the knowledge that you have distinguished between perceiving your own inherent motility and the inherent motility of the patient. Perhaps the experiment when one hand compares the vitality of a subject's forearm with the other hand's perception of no vitality of a table surface can be extended so the table surface reflects the physician's inherent motility. I had an experience where both hands were on an object to be moved by another and I was to describe the motion. I was sure I felt movement, but the movement I felt was not the movement of the object of concern.

A positive reinforcement would be the polygraphic representation of various rhythmic impulses received from the patient's body by way of electric sensors at the same time the student is perceiving impulses by way of his hands. By looking at the written record the student would have the opportunity for correlation with his diagnostic touch.

When I studied with the D.O.s in New England, we formed two columns on a blackboard. One was headed "fact" and the other headed "theory." Whenever we argued, we'd stop and ask, were we arguing about fact or theory? It was usually theory but we were trying to support it as fact. Many items were moved from the fact to the theory column. Facts were agreed upon; theories were discussed to learn about them, to clarify them, but they did not have to be accepted by all. As physicians when making explanations to patients we tend to relate our theories as facts. As instructors of students without the instructors' experiences it is better for communication to identify that which is fact and that which is theory. That which is fact should be supportable with documentation; that which is theory should have some logic.

The criteria for advancement through whatever number of steps or stages are determined need to be in writing. Examples are like those mentioned under prerequisites plus more effective skills that only the skilled can describe.

Feedback among instructors is a necessity for perfecting a program that will do more in less time. Sharing problems experienced with individuals in small groups may identify problems that have been ignored or problems for which others have successful resolutions. Instructors of small group practice sessions at MSU/COM met weekly 2 years ago as a new program of instruction was instituted. The problems shared and the resolutions offered within the group enhanced the program. A year ago, some different instructors were in the group and both regular and new instructors continued to share to increase the efficiency of the program.

If the present uniqueness of the osteopathic physician is his/her ability to feel the inherent motility of the patient, and I accept that it is, then an acceleration of the present instruction is in order. I have suggested in keeping with objectives stated in 1938 by Dr. Thomas L. Northup and others, that the Academy add this acceleration to its agenda. I have perceived and let a problem come through to me and I believe the Academy and its members have the mechanism to increase the vitality of a school chartered to improve upon the practice of medicine.


1. Barnes, M.W., Ed.: The Northup Book. A memorial tribute to Thomas L. Northup, D.O. (newsletter). Year Book; American Academy of Osteopathy, Newark, Ohio, 1983

2. American Academy of Osteopathy Year Book. American Academy of Osteopathy, Newark, Ohio, pp. 94-9, 1944

3. Nicholl, W.: Fifty years of osteopathic technique. Presented at New York Academy of Osteopathy meeting, Jan 59

4. Still, C.: Personal communication, 1941

5. Hildreth, A.G.: The lengthening shadow of Dr. Andrew Taylor Still. Arthur Grant Hildredth, Publisher, Macon, Missouri, 1938, p. 45

**6.** Heyn, D.: Chiropractic's new twist. Is "motion palpation" the answer to back pain? Health, pp. 13-4, Mar 82

**7.** American Academy of Osteopathy, Newark, Ohio: Personal communication, 1981

**8.** Lay, E.M.: Where is your focus of attention? Cranial Academy News Letter 35:1, Winter 82

**9.** Eschtruth, P.L.: A pathway to inner peace. Cranial Academy News Letter 36:1, Fall 82

**10.** Cranial Academy News Letter 36:4, Spring 83

**11.** Kaslof, L.J.: Wholistic dimensions in healing. Doubleday and Company, Inc., Garden City, N.Y., 1978

**12.** Hastings, A.C., Fadiman, J., and Gordon, J.S., Eds.: Health for the whole person. Westview Press, Boulder, Colo., 1980

**13.** Flynn, P.A.R.: Holistic health. Robert J. Brady Co., Bowie, Md., 1980

**14.** Mattson, P.H.: Holistic health in perspective. Mayfield Publishing Co., Pala Alto, Calif., 1981, p. 2

**15.** Goodridge, J.P.: Who is the whole man? Year Book, American Academy of Osteopathy, Newark, Ohio, 1968, p. 37

**16.** Tubesing, N.L.: Whole person health care. Philosophical assumptions. Wholistic Health Centers, Inc., Hinsdale, Ill., 1977, p. 1

**17.** Northup, T.L.: Our noble heritage. The Andrew Taylor Still Memorial Lecture; JAOA 55:289-93, Jan 56

**18.** Licht, S.H.: Massage, manipulation and traction. Waverly Press, Inc., Baltimore, 1960

**19.** Rogoff, J.B., Ed.: Manipulation, traction and massage. Ed. 2. Williams and Wilkins, Baltimore, 1980, p. 5

**20.** Kewalramani, L.S., et al.: Myelopathy following cervical spine manipulation. Am J Phys Med 61:165-75, Aug 82

**21.** Northup, G.W.: Thomas L. Northup, D.O., 1885-1982 (editorial). JAOA 82:243, Dec 82

**22.** Frymann, V.M.: Motion. The difference between life and death. Year Book; American Academy of Osteopathy, Newark, Ohio, 1977, p. 105

**23.** Op cit., ref. 22, pp. 108-9 (Part IV, Its study in the workshop.)

**24.** Frymann, V.M.: Palpation. Year Book; American Academy of Osteopathy. Newark, Ohio, 1963, p. 29

**25.** Op cit., ref. 22, p. 111

**26.** Becker, R.E.: Diagnostic touch. Its principles and application. Part II. Year Book; American Academy of Osteopathy, Newark, Ohio, 1964, p. 158

**27.** Op cit., ref. 24, p. 21

**28.** Op cit., ref. 22, pp. 109-12

**29.** Op cit., ref. 24, pp. 28, 30

**30.** Op cit., ref. 26, p. 156

**31.** Frymann, V.M.: The law of mind, matter, and motion. Scott Memorial Lecture.Year Book; American Academy of Osteopathy, Newark, Ohio, 1973, p. 20

**32.** Wales, A.L.: Learning by discovery. Cranial Academy News Letter, 34:1,4-5, Spring 81

**33.** Op cit., ref. 22, p. 112

**34.** Allen, P.V.B.: Improving your skills. Year Book; American Academy of Osteopathy, Newark, Ohio, 1964, p. 149

**35.** Northup, G.W.: The role of manipulative therapy in the practice of medicine. JAOA 71:537-42, Feb 72

**36.** MacBain, R.N.: Osteopathic manipulative therapy 1971. Which way, up or down? 1971 Academy Lecture. Year Book; American Academy of Osteopathy, Newark, Ohio, 1972, p. 3

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Dr. Goodridge is a professor in the Department of Family Medicine, Michigan State University—College of Osteopathic Medicine, East Lansing, Michigan.

Dr. Goodridge, Department of Family Medicine, B-215 West Fee Hall, MSU-COM, East Lansing, Michigan 48824.