FROM THE ARCHIVES

*Anthony G. Chila, DO, FAAODist, FCA*

# Quality of Care: An Assessment of the Contributions of Osteopathic Medicine

## Abstract

Since the advent of Medicare in 1965, the concept of quality of care in medical practice in the United States has been under review, and a revision of ideas and responsibilities to the patient (consumer) has had a major impact on the system of delivery. In little, more than ten years, there have been major changes in the health care system in the United States, with a necessary delineation of the contributions to total health care of followers of two separate and distinct philosophies of medicine that are coexistent and recognized equally by the legislation of the United States. The purpose of this paper is to consider the quality of care rendered by the minority school of medicine through the services of the osteopathic community hospital and possible methods of improving it.

## Historical Survey

### *Medicare*

The formal articulation of the concept of quality of care in the delivery system of American medicine was incorporated in the Medicare Act of 1965. This act was passed by the 89th Congress and signed into law by President Lyndon Baines Johnson. It was designed to provide hospital and nursing-home care for persons aged 65 or over, under the Social Security Act. It was also the culmination of more than 20 years of active political efforts to provide equality of care for recipients of health services in the United States. On becoming a law, this act represented the first defined instance of governmental participation in national health care in the history of this country. The Medicare Act was signed into law in Independence, MO, in the presence of former President Harry S. Truman, as a tribute to his long-standing belief in the right of every American citizen to equal access to the health care system.

Recognition of the 'dual philosophies of medical practice in the United States was accorded by provisions in this legislation that accreditation for continuing participation in Medicare benefits to hospitals must be via existing standards of the American Hospital Association or the American Osteopathic Hospital Association. Implicit in such recognition was the right of the American public to a choice of health care. Public acceptance of a dual system of health care had been a fact for at least half a century prior to the enactment of this legislation. The crucial point involved in analysis of the impact of legislation with regard to any health care program for any segment of the United States population

## Keywords

Osteopathic community hospital, OMM, health legislation, primary care, osteopathic profession, osteopathic research

## Editor Note

This article from the archives has been formatted to comply with *The AAO Journal*'s style guidelines, but original language, spelling, and punctuation have been retained per its original publication in the 1977 AAO Yearbook.

This article was the FAAO thesis for Anthony G. Chila, DO, FAAODist, FCA. He was a professor emeritus of family medicine at Ohio University, and was conferred fellowship in the American Academy of Osteopathy in 1977. He passed away on April 1, 2022.

lies in the fact that the concept of vox populi historically had been abrogated by protagonists and antagonists of duality of medical philosophy so that ultimate recognition of the two philosophies by government became unavoidable.

### Public Law 92-603 (Professional Standards Review Organization)

The Bennett amendment, otherwise known as the prototype legislation for self-regulated professional standards (PSRO), contained the seminal idea that the health professions are the groups most capable of determining the standards under which their services may be rendered to the patients under their care. Despite the generally negative views accorded this legislation by the medical profession, several operating PSROs have given evidence through self-regulatory activity of their function and opinions with regard to the quality of care. Conditional PSRO groups are active in Arizona, Colorado, Utah, Wyoming, Montana, California, Minnesota, Mississippi, Tennessee, Pennsylvania, and Delaware. Some of the most advanced are centered in Minneapolis, Sacramento, and Salt Lake City.[1]

The official position of the American Osteopathic Association is to recognize and support peer review as enacted under Public Law 92-603. The association has contended further that the provisions of that law should be incorporated completely into any program of national health insurance. In November 1974, the association proposed the development of model sets of osteopathic critical admission criteria for use by local PSROs. In May 1976, the draft document of osteopathic critical screening criteria developed by the American Osteopathic Association was approved by the National Professional Standards Review Council.[2] Copies are available through the Washington office of the AOA.

### Certificate-of-need legislation

At its midyear meeting of 19 February 1975, the AOA Board of Trustees adopted the following statement[3] regarding separate identification of osteopathic facilities under certificate-of-need laws:

1. Needless expansion of hospitals is not in the public interest.
2. All hospitals, allopathic or osteopathic, should be allowed to expand their facilities on the basis of demonstrated need.
3. Osteopathic facilities should be considered separately under certificate-of-need laws because of the greater number of allopathic beds in any given area at any given time.
4. That segment of the public that seeks out osteopathic health care should not be subjected to overcrowded conditions simply because there are beds available in allopathic hospitals. The patient's free choice of physician also means free choice of hospital.
5. The osteopathic profession is a separate school of medicine with a distinct philosophy of health care, different training requirements, different accrediting procedures, and a distinct and unique emphasis on treating disease.

### National health legislation

National health insurance has been endorsed by the American Osteopathic Association since 1970. The statement of position adopted by the House of Delegates in July 1974[4] and expanded in 1975 is the most recent statement of the profession's attitude. A 1974 statement by the House of Delegates' emphasized the "separate and distinct" nature of osteopathic medicine.

Public Law 93-641 apparently specifies sweeping changes in the health care environment for the period from July 1976 to January 1979.

## Primary Health Care

### The Javits Report

The ongoing interest of the federal government in health care is reflected in the work of the Senate Committee on Labor and Public Welfare. The ranking minority member, Senator Jacob Javits (R, New York) emphasized his belief that colleges of medical training "must make a special effort in the development of the primary care physician."[6] The results of a survey entitled "Primary Care Training Programs in Schools of Medicine and Osteopathy" were published in the Congressional Record.[7] The highly successful emphasis of the osteopathic profession on the production of primary care physicians was noted in this report, in which it was stated that from 60% to 85% of osteopathic graduates enter general or family practice.

### Primary health care: The AOA position

On 9 January 1976, AOA President Earl Gabriel addressed the project steering committee of the Institute of Medicine (IOM), National Academy of Sciences.[8]

IOM had begun a two-year study "to develop a cohesive manpower policy for primary care." This study was funded by the Robert Wood Johnson and W.K. Kellogg foundations. Dr. Gabriel offered the AOA's statement that osteopathic medical education is "a viable, proven model which can provide solutions to the most urgent problems of primary health care delivery in the United States today."[8]

Government support: A turning point. Harvey[9] stated that since the enactment of Public Law 89-290 (Health Professions Educational Assistance Amendments of 1965), schools of osteopathic medicine have been able to receive grants for educational and research programs. The following quotation from his article is most pertinent to consideration of the profession's evaluation of itself in the delivery of primary health care:

"Most definitely the government is interested in all phases of health care, and most definitely it is interested in osteopathic medicine. What is sorely needed by federal agencies is information on the osteopathic profession. Well-documented and well presented statistics on our profession are practically nonexistent. Research data are insufficient. Statistical information on students and graduates that serves as research material for those staffers supplying information to Congress does not give an accurate picture of osteopathic medicine. In the Washington office of the American Osteopathic Association, there is a strong program designed to provide information to federal committees and bureaus and to ensure osteopathic representation before Congress. Also in the offices of the American Association of Colleges of Osteopathic Medicine, an effort is being made to obtain this kind of statistical data from the schools of osteopathic medical education."

## The Osteopathic Profession: Self Assessment

### *A. Research in support of principles.*

Even after one century, the application of osteopathic manipulative therapy in its holistic context is not complete. Korr[10] stated the premises from which the osteopathic profession must mature during its second century of existence:

"I propose to show: (1) that, contrary to a myth that has been allowed to impede their wider application, osteopathic principles and methods have a solid basis in biomedical research and biologic mechanism; (2) that osteopathic palpatory diagnosis and manipulation, by virture of the mechanisms through which they operate, as well as their demonstrated efficacy, represent, potentially, a truly great and urgently needed contribution to total health care; (3) that osteopathic principles and methods not only are invaluable in the care of the individual, but that they offer reliable guidelines to the reformulation of the objectives, priorities, and premises of clinical practice generally and to the needed restructuring of health care delivery in the nation as a whole; and (4) that the osteopathic profession must now decide whether to seek the fullest development of the distinctive contributions for which its hard-won rights and recognitions have prepared it, or whether to accept those rights and recognitions as the ultimate fulfillment of its purpose."

B. The rotating internship

(I). In his presidential acceptance address, Gabriel[11] indicated that the osteopathic profession needs to consider expansion of existing rotating internships in its teaching hospitals as well as the possibility of developing a new form of internship program. A significant reason for this emphasis lies in the contention that osteopathic hospitals help demonstrate the principles of osteopathic medicine and, accordingly, a different approach to health care.

Vigorito[12] elaborated on this viewpoint, mentioning possibilities for modification of the classical rotating internship to emphasize specific training for entrance into general practice.

Both the differentiation of the osteopathic from the allopathic approach to health care and the emphasis on general practice have long been hallmarks of the osteopathic profession.

### *C. Osteopathic specialty practice.*

It is not possible to separate the application of osteopathic tenets from the various disciplines of specialty practice. To do so in the hospital environment is tantamount to false delineation of levels of care.

The constantly reiterated concepts of osteopathic holism, neurologic man, respiratory and circulatory aspects of the musculoskeletal system, energy expenditure, and the self-regulatory mechanisms of the body have been examined by Greenman.[13]

### *D. The uniqueness of osteopathic training.*

The first century of existence of the osteopathic profession

was generally characterized by ongoing legal battles for legislation designed to recognize the completeness and distinctness of health care offered by its members. It was not until 1973 that Mississippi became the last state to enact a modern law governing the licensing of osteopathic physicians. In March 1974, the state of California repealed the 12-year-old statute prohibiting the licensing of new doctors of osteopathy. Thus, truly unlimited national licensing in 50 states and the District of Columbia was finally a reality during the centennial year of the profession.

The Court of Appeals of Arizona, in the case of Dr. Gary Wayne Ferris, was the agency by which unlimited licensing was secured. Medical World News[14] summarized the decision of that court as follows:

" . . . legislative intent and public policy in Arizona clearly regard the medical and osteopathic practices as separate professions with separate licensure requirements. That the two professions may be 'similar' is not legal ground for ignoring the statutory requirement that an osteopathic physician in Arizona must receive training that 'bears the distinguishing and vital osteopathic concept.' "

The case was reported in detail also in The Osteopathic Physician.[15]

## The Osteopathic Community Hospital

### *Responsibility for the future*

The osteopathic profession has introduced and substantiated the concept of somatic dysfunction in health and disease. Public and legal recognition of the role of the profession in the provision of health care has added a new dimension which Goldstein[16] has designated as the third frontier. He specifically mentioned two concepts which differentiate public health community medicine from episodic medicine: (1) communal action and (2) the maintenance and promotion of health. Baxter[17] indicated that the osteopathic holistic philosophy encompasses service to man as he is part of his environment, and it would seem to make the profession and its hospitals natural centers for community medicine.

### *Impact in the community*

Early in 1976, Michael F. Doody, president of the American Osteopathic Hospital Association, addressed the Federal Council on Wage and Price Stability in Washington. With respect to the services provided by osteopathic hospitals during 1975, he provided the following noteworthy statistics: 205 osteopathic hospitals provided 6.1 million days of inpatient care and also provided care in 2.8 million outpatient visits. The osteopathic hospitals have a combined total of 23,030 beds and employ 60,000 persons. A total of $959 million was spent during the last calendar year.

The AOA[18] has stated that 86% of osteopathic physicians are engaged in general practice. This number represents approximately 5% of physicians in the United States, but they provide health care to 10% of the population.

### *The osteopathic patient*

A patient admitted to an osteopathic community hospital has made a commitment to the idea that the care rendered will be of a different standard from that offered elsewhere. His expectations call for answers to several questions:

(1) Is every patient entering an osteopathic hospital entitled to a complete biomechanical examination which reflects an osteopathic approach to the presenting complaint and its extension to considerations of secondary or tertiary problems?

(2) Does the patient have the right to expect that the biomechanical examination will be done by the attending physician, any specialist consulted regarding case management, or a hospital-based physician doing only biomechanical consultation for the entire institution? Does the patient have the right to expect that the nature of the immediate disease process may be best served if the three physicians aforementioned cooperate in a biomechanical interpretation and see that parameters for care both during and after hospitalization will be established to improve his well-being from the standpoint of preventive medicine rather than management of an episodic illness?

(3) Does the patient have the right to expect full participation of the hospital house staff in an accredited institution (student, intern, resident) so that the teaching of the osteopathic philosophy attitude is extended in depth?

(4) While it may be true that institutional distinctiveness cannot be evaluated by the number of osteopathic manipulative treatments given during a patient's hospital stay, it is appropriate to ask the foregoing questions in order to focus the responsibility of the profession on the proper use of its institutions for the application of the osteopathic concept.

Finally, does the institution fail in its obligation to the public it serves if it does not answer these questions satisfactorily but purveys the services of a minority group with a distinctive approach to disease processes?

## The Osteopathic Profession: Self Assessment (II)

### A. The osteopathic concept

If the emphasis used in describing the osteopathic concept is on theory and methods, then an interpretation of the profession's philosophy retains and projects a dynamism, the applicability of which in the management of the human organism's response to disease is manifold. Such a viewpoint is found in the interpretation of the osteopathic, concept rendered by a special committee study at the Kirksville College of Osteopathic Medicine.[19]

### B. The McKillop memorandum

In February 1966, the AOA Board of Trustees passed a resolution that a committee in each osteopathic hospital be required to evaluate the utilization and application of osteopathic methods. This committee was to be composed of representatives of each organized department and the suggested name was Committee on Utilization of Osteopathic Principles and Methods. On 8 December 1972, in a memorandum discussing documents pertaining to this required committee. William McKillop,[20] then administrator of the AOA Office of Hospital Affairs, reminded osteopathic hospitals of the requisite status of this committee and its function. The following remarks from his memorandum are pertinent:

"We make bold to suggest that you coerce your staff into serious study and prompt implementation of the functions of this committee. It is a sad commentary on our generation of osteopathic physicians and administrators that very few osteopathic hospitals, according to the reports of our accreditation and postdoctoral training inspectors, teach and practice osteopathic concepts and methods.

> On a more pragmatic, less idealistic level, I would remind you that an established and functioning committee on utilization of osteopathic concepts and methods is a requisite for AOA accreditation.

### C. The recording of musculoskeletal findings

From 1966 to 1968, the Hospital Assistance Committee of the Academy of Applied Osteopathy worked to establish a uniform method by which the osteopathic profession might record its distinctive diagnostic findings and therapeutic procedures. The definition of the term somatic dysfunction was accepted by the Commission on Hospital and Professional Activities for use in the 1968 edition of the Hospital Adaptation of International Classification of Diseases (H-ICDA).21 Since 1 January 1969, it has been possible for hospitals using the Professional Activity Study-Medical Audit Program (PAS-MAP) to utilize "somatic dysfunction" as well as "osteopathic manipulative therapy" in the coding procedures for patient discharge summaries. The definitions of these terms[21] are as follows:

> "Somatic Dysfunction (Osteopathic): Impaired or altered function of related components of the somatic (body framework) system; skeletal, arthroidal, and myofascial structures, and related vascular, lymphatic, and neural elements."
>
> "Osteopathic Manipulative Therapy: A form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders."

During the past seven years, then, it has been possible for physicians to utilize osteopathic terminology in dealing with third-party carriers in three areas: H-ICDA (Hospital Adaptation of International Classification of Disease, Adapted); ICDA (International Classification of Disease, Adapted); and CPT (Current Procedural Terminology). Rumney[22] fully discussed the work of the Hospital Assistance Committee, of which he was then chairman. He wrote further[23] regarding the use of osteopathic terminology in a paper presented at the third annual postgraduate seminar of the American Academy of Osteopathy (March 1971) in Colorado Springs.

### D. The rotating internship (II)

The official educational view of the osteopathic profession remains that the rotating internship is a formal year of postdoctoral study for the recently graduated doctor of osteopathy. That is, the profession indicates to its students that this year represents the avenue for entrance to general practice of more than 70% of the graduates of the osteopathic colleges. Apparently because of the significance of this in terms of primary care, an amendment to the Health Professions Educational Assistance Act, S. 3239, adopted by the United States Senate, has benefited freestanding osteopathic rotating internships.[24] The impact of the recently graduated doctor of osteopathy on the quality of care in an osteopathic community hospital is sufficiently important that it must be given more than passing attention. On the basis of the scope of training offered during the four years of predoctoral training, the

most reasonable assumption is that all graduates of osteopathic colleges have been trained uniformly in the philosophy of osteopathic medicine and are therefore ready to be absorbed into the mainstream of practice via the osteopathic community hospital. A further assumption is that the quality of teaching at the predoctoral level is such that uniformity in the understanding of theory and methods exists, as it were, in a core program of knowledge in all the osteopathic colleges. If this is true, then the profession has demonstrated successfully and satisfactorily the validity of its approach to health care. If this is not true, then legislative support for the profession's progress is warranted only for the production of qualified general practitioners, regardless of the philosophy of care.

If each graduating class represents the most recent generation of professionals to have been given the most up-to-date understanding of the scientific support of osteopathic theories and methods as well as their clinical application, then the rotating internship becomes a 12-month program of mutual benefit, in which the attending generalists and specialists become recipients of the recent instruction of the intern, while the experienced practitioners in turn help the intern become acclimated to the clinical setting.

Given such a relationship, the effects on the quality of patient care should not be minimized. Its impact can be assessed by careful coordination of the role of the committee of osteopathic principles and therapeutics with those of staff clinical departments, the medical records department, and the institutional teaching program.

It is noteworthy that the AOA House of Delegates, in August 1976, overwhelmingly approved a two-year "amnesty" program for the retraining of osteopathic physicians who have had allopathic training." The program includes a one-year rotating internship with appropriate instructions in osteopathic principles of manipulative therapy and palpatory diagnosis and extends to specialty training programs.

### E. Research

1. Osteopathic research

The encouragement of osteopathic research is one of the stated objectives of the AOA. Funding of investigations directly related to osteopathic philosophy and practice can be accomplished on the recommendation of the Bureau of Research. Funds are actually made available through the National Osteopathic Foundation and the A.T. Still Osteopathic Foundation and Research Institute.

With respect to research problems, Prupes[26] wrote:

> Osteopathic researchers agree that there needs to be more clinical observation and reporting on the influence of osteopathic diagnosis and treatment on health status. Crucial prerequisites are the development of universally acceptable standards for placebo manipulative treatments and the documentation of interexaminer correlation of findings in osteopathic examinations. These are necessary if results obtained by different investigators are to be compared.

2. Spinal manipulative therapy

In February 1975, a workshop on "The Research Status of Spinal Manipulative Therapy" was held at the National Institutes of Health in Bethesda, MD. This meeting was organized by the National Institute of Neurological Diseases and Stroke in response to a request from the Congress of the United States given in 1974. The results of this meeting are expected to be published by the Government Printing Office. Tilley[27] reported on this meeting, at which representatives of allopathic medicine, osteopathic medicine, and chiropractic were discussants.

### F. Certification in manipulative medicine

The possibility of official certification in osteopathic manipulative medicine was considered in a series of articles[28-33] representing the opinions of several of the leading educators within the osteopathic profession. Objectivity was maintained throughout all of the presentations, with careful delineation of arguments for and against certification. The opinions of individual authors evidently favored certification. The fact that this is not a new thought was indicated in the description of the genesis of the proposition in 1961.

At present it appears that certification is practical, * since the AOA has indicated that only 10% of the profession specializes in manipulative therapy and less than 50% will administer osteopathic manipulation.[34]

An indication of the future applicability of certification in manipulative medicine may be found in the work of Stiles,[35] in the establishment of an osteopathic diagnostic and treatment center in Waterville, ME. Dr. Stiles functions as the director of osteopathic medicine, maintaining broad contact with all hospital departments and specialties in the osteopathic management of hospitalized patients.

With a little imagination, one can see the possibilities for statistical analysis of the therapeutic import of osteopathic manipulative therapy in the hospital environment. A similar center has been opened recently in the Westview

Hospital in Indianapolis.[36]

## Conclusion

The osteopathic profession has existed for one century in the framework of a philosophic approach to the management of disease which requires a separate and distinct voice in relation to the majority view of medical practice in the United States. As a distinctively American contribution to the mainstream of medical thought, the profession's premises have been employed successfully on an empiric basis, scientifically substantiated, publicly accepted, and legislatively defined. As propounded by Andrew Taylor Still [MD, DO], the purpose of this minority viewpoint was to catalyze a change in medicine's progress toward a concept of holistic wellbeing and the improvement of environmental adaptation to gravity. At the time when all the struggles against impediments were won, accepted intraprofessional attitudes appear to have lost sight of the fine line which separates true intellectual greatness from the obscurity of mental failure. Chapman[37] summarized the views of Korr in these words: "Seldom in history has an organized group of men and women perceived, grasped, and then seemingly relinquished a greater opportunity."

In order to regain its perspective and provide enlightened leadership toward its original goal, the profession must consider several steps:

1. Active restructuring of teaching methods in all the osteopathic colleges so that a core curriculum of osteopathic theory and methods will provide a uniform philosophy in the predoctoral years.
2. Expansion of the teaching program during the year of rotating internship. Whether in a traditional 12-month program or in some modification of services for increasing exposure to the community's facilities, the intern must have the greatest possible clinical orientation to the community application of the holistic view of medical practice.
3. Improving and expanding analytic methods as to the effect of osteopathic manipulative therapy on disease processes. Research in this area is sorely needed to provide the basis for ongoing support of third-party interest in the potential of this profession's separate and distinct philosophy. The rotating internship in the osteopathic community hospital provides an excellent vehicle for the establishment and continuity of such clinical research.
4. Analysis of the quality of care per se. This appears to be an appropriate function for the committee on osteopathic principles and therapeutics. As constituted by regulations of the AOA, this committee at each hospital should represent all divisions of the medical staff and provide the broadest impact on the hospital teaching program. With the fullest possible utilization of osteopathic principles by each physician on the attending staff, the committee's analytical function may be carried out easily by either a review of active charts of currently hospitalized patients or retrospective review of charts of discharged patients, or both. On the assumption that every patient hospitalized in an osteopathic institution is deserving of at least one complete biomechanical examination regardless of the admitting diagnosis, then no patient will be deprived of a parameter of care unique to the osteopathic profession. Statistical retrieval studies can be accomplished by close cooperation with the hospital's medical records department, utilizing the PAS-MAP approach, or any similar program. Retrieval studies tied in with ongoing clinical research programs in every osteopathic hospital with an approved teaching program provide unlimited opportunities for the profession to assert its leadership in the study and management of disease.
5. Fellowship in the American Academy of Osteopathy (AAO) recognizes excellence in the use of osteopathic principles. If future developments indicate the need for certification in manipulative medicine, then the AAO will be the agency through which this can be accomplished.* Once such certification becomes a reality, the skills of the certified specialist, if available in the teaching hospital, will provide the general practitioner an extra dimension in the care he can offer his

*In July 1977, the AOA Board of Trustees approved the establishment of the American Osteopathic Board on Fellowship of the American Academy of Osteopathy. The purposes of this board are to define and determine qualifications of DOs who desire certification of special proficiency in the knowledge and application of osteopathic structural diagnosis and manipulative management, to conduct examinations for this purpose, and to issue certificates to those found qualified.

patients. This is in accordance with the concept of Stiles[39] of a director of osteopathic medicine for an institution. This specialist can supplement the contribution of the Committee on Utilization of Osteopathic Principles and Methods.

A final word is in order with regard to the evolutionary tendency of medical thought. For most of its first century of existence, the osteopathic profession occupied the position of a digression vis-a-vis the monolithic philosophy of the allopathic profession. This is no longer the case. Within the allopathic school itself, interest in manipulation is increasing. Although allopathic physicians do not possess the knowledge demonstrated by the osteopathic school, the fact that this change has occurred demonstrates that the minority profession is now challenged by the need to provide a high caliber of interchange of thought, as originally advised by Andrew Taylor Still.

The presence of representatives of allopathic medicine, osteopathic medicine, and chiropractic at a workshop discussing spinal manipulative therapy offers another warning to the osteopathic profession, since all the manipulative viewpoints were represented. Again, the osteopathic profession must provide a high caliber of interchange of thought.

The osteopathic profession today is numerically smaller than either the allopathic or the chiropractic group. Failure to continue to document the value of its philosophy significantly via its hospital teaching programs is equivalent to reducing the profession's standing to a negative and naive "MD-plus" categorization by all who view it: the public, legislative bodies, the allopathic and chiropractic groups, and osteopathic physicians themselves. Such an occurrence would serve to reduce the followers of a century-old example of philosophic and academic excellence in intellectual professional dissent to the status of a splinter group. It is past time for the osteopathic profession to ask itself what it considers its role to be in the delivery of health care.

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