



JOURNAL

of the Pennsylvania Osteopathic Medical Association

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James N. Cornwell, DO

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Steven G. Ward, DO

Attention Writers...

The Journal of the POMA is seeking input from YOU!

The Spring 2019 issue will focus on your solutions to the healthcare debate. The politicians and insurers have stacked the deck and tend to forget about the patients and physicians so how would you do healthcare?

There is no word limit and everyone is welcome to contribute.

**E-mail entries or questions to the JPOMA Editor c/o bdill@poma.org.
The deadline for submissions is February 1, 2019.**

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FROM THE EDITOR'S DESK

Mark B. Abraham, DO, JD

Originally, I thought that we could have an issue which was more of a follow-up discussion regarding opioids, pain, the epidemic and related items. However, it became apparent that no matter how cliché it may be, looking forward into the future of medicine and health care garnered more interest. As I have written before, this is your Journal. This is your organization.

The changes in medicine, technology, understanding of disease processes, communication, etc., just continue to grow. Is all of this for the better? Maybe, maybe not. Some of that is a mix of personal preference and ultimately results oriented. As an example, when I was in medical school, a lot of the virtual and simulated technology was developing and starting to be included in the curricula of medical school — osteopathic and allopathic. Schools now have simulation labs which allow students to learn to perform many procedures and surgeries. The same technology is used by post-graduates and attendings to practice, refine or learn new skills. What it does not and cannot do, no matter how good the supporting software, is replicate everything that the physician encounters during a procedure on a living, actual patient. Anatomical variants, unexpected complications or equipment failures, and other stressors all play a role. The pressure involved when working on a real patient with real life and death consequences is always greater than working on a simulated patient. Practice and learning are necessary to help minimize the adverse results and consequences. Do we need the technology? Yes. Is it a benefit that it can be included in the curricula? Definitely. Is it perfect? No way.

I remember being on my first medical school rotation and scrubbed in on a gallstone ileus. As with most students, I was holding the retractor. The attending grabbed my hand, looked at me and said “put your hands in here.” With my hands now into the patient’s abdomen and covered in blood, he added, “now you are involved in surgery.” The difference between the gross anatomy lab and living patient was obviously vastly different. We all know what that means. This is what I also mean when comparing technology and physical contact with the patient — be it exam, procedure, surgery or even just face-to-face communication.

Telemedicine has a role. Radiologists can review films from home or half-way around the world so stat results can be determined after the

hospital’s radiologist has left for the night. It also can help with guiding management of certain cases such as stroke management. However, it is hard to determine whether or not someone truly has strep throat vs. mono if you cannot feel the lymph nodes, examine the abdomen, look into the mouth and oropharynx as effectively as when you are holding the tongue blade.

In a previous column, I wrote that medical school should be expanded by one year. The advances and technology are happening so fast that the volume of information for students to learn and experience cannot occur in just four years. Do the students need to be proficient in everything? Of course not, they are students. Should they be educated and made aware of as much as possible in order to be know how to manage and guide the patient, even if just to make sure that when the student is the physician, the student knows what else to consider? I think the answer to that is ABSOLUTELY.

There needs to be a balance between the books, the live patient, the standardized patient and the simulated, virtual patient. All help teach and educate. Effectively integrating them is the key. I think that the nature of osteopathic medicine and how we examine patients allows the osteopathic schools to do this better. We already teach a multi-faceted exam. We don’t just listen, we feel and palpate. Remember TART? Adding the simulators as an adjunct takes it to another level.

As we head into 2019, changes and advancements will continue. What they are? We will see. Will there be further advances in detection and treatment of disease with genetic and immune therapies? Will there be similar advances in stimulating the body’s own systems and defenses to combat pain? Perhaps.

I hope everyone has (had) a wonderful Holiday Season. Best wishes for a happy, healthy, and successful 2019 to you and your families.

For the next issue, I would like to discuss what you think should be a solution to the healthcare debate? The politicians and insurance companies have stacked the deck and tend to forget about the patients and physicians. Remember, whatever the solution is, there needs to be a way to pay for it. I want to hear your ideas. I know all of you have them. This is your time to share!

Collegially,
Mark B. Abraham, DO, JD



Mark B. Abraham, DO, JD
Editor-in-Chief

POMA 2019-2021 Strategic Plan



Background

The citizens of Pennsylvania have just completed an election process. The candidates were chosen based on the will of the people. We wish all the candidates success as they try and make our Commonwealth a better place to live and we will offer to them medical council as they wrestle with Public Health issues. We at POMA also want to make our Commonwealth a better place to live and we are about to initiate a Strategic Plan. Give me a few minutes to tell you about it as you read this article. Alice Walker wrote "keep in mind the "present" you are constructing, it should be the "future" you want." (author of *The Color Purple*). In that spirit let me begin.

Some organizations are divided into different divisions based on the good of the whole. Each part is integral to the other. Today I want to tell you about our Strategic Plan that is being molded by the hands and voices of our members. About a year and a half ago POMA asked a research group to survey our members regarding what should be the future goals of our organization and strategies to achieve them. Then a small group of our Board members met in 2018 to review the findings and organize the information into a format that would allow POMA to develop a Strategic Plan. The key components identified were arranged into four main pillars, but keeping in mind that Osteopathic Distinctiveness was a uniting thread. The

four pillars identified were: Education, Influence/Advocacy, Communication and Community. We then had four POMA leaders participate in conference calls on the individual pillars. The goal was to ask what components should be addressed under each pillar. Those findings were then presented to the full Board this past November for review and additional comment. The big plan targets improving POMA's footprint across the state at many different levels. It will bring our state society to the forefront with our members, our citizens and our legislators. Our members, students and residents will be addressed first but by starting there we naturally send out offshoots that affect our citizens and communicate policy to our legislators. You will start to see subtle changes in the next few months and bigger changes over the next year.

I will now try and give you a thumb nail sketch of some of our plans based on your original input. Plans to increase our online CME options are high on the list. We realize that everyone cannot always get to a convention or a meeting. By providing improved online CME, including state required CME, we hope to improve the value we bring to our members. We are planning on creating a user-friendly app that will allow you to navigate easily to your CME and other topics of interest without a lot of extra clicks. Videos will be available covering Osteopathic techniques. We also hope to have a louder voice in Harrisburg adding to an increase in developing public policy and advocating for our profession by educating members on how to converse knowledgeably with government officials. Improvement of district meetings are also planned by varying what can be offered at the meeting and even expanding geographic boundaries to include other districts. Addressing our resident and student needs was a recurrent theme and outreach will be done. Many other items are on the agenda and will be described as we move forward. We are not at the implementation phase but some of our target times are in the near term and some will take a few short years. The state of POMA is healthy and we feel constantly rejuvenated by member response and input and the great work of our staff.

Warren Buffet said, "someone is sitting in the shade today because someone planted a tree a long time ago." We at POMA are planting our trees today, tending to the ones already growing and buying seeds for the next crop. That is how I envision our strategic plan. See you at the harvest!

Respectfully,
Joan Grzybowski, DO
POMA President

Outline of POMA's Strategic Plan

The Pennsylvania Osteopathic Medical Association is focused on delivering programs, products and services that address the four strategic pillars: Communication, Community, Education, Influence.

Pillar: Communication

POMA will expand capacity and capabilities surrounding digital and online content, creation, distribution and communication. Digital competencies are an essential component of modern business strategy and, without a sufficiently robust platform, the ability of POMA to successfully achieve its goals is limited.



Goal: *POMA will develop robust advocacy, CME and practice support, and communication digital infrastructure.*

Objective 1: Create digital and online offerings to provide a platform for CME and advocacy efforts targeting patients and their families, and policy makers.

Strategies: Identify online and digital infrastructure needs.
Ensure infrastructure supports delivery of educational content in smaller increments for constituent convenience.
Integrate online advocacy program.

Objective 2: Assess existing content and communication creation and production processes.

Strategies: Conduct a communications audit.
Review and incorporate audit recommendations.

Objective 3: Develop assessment of digital infrastructure necessary for sustaining and communicating a substantial online presence.

Strategies: Distribution of information by text.
Develop POMA App.

Pillar: Community

POMA members are increasingly challenged to find time away from their practice and families. To improve member value, POMA will need to make advocacy and education more locally accessible and, to combat the stress and resulting burnout, develop compelling and supportive communities of peers.



Goal: *POMA members are engaged and advocate for osteopathic principles.*

Goal: *POMA supports districts (other geographic), subject matter and/or other types of peer groups to act as locally led mechanisms for education, practice management and, career and personal support.*

Objective 1: Evaluate the relative strength of existing formal and informal communities, such as districts, to determine methods to improve local engagement.

Strategies: Assess the current district structure to determine if it is meeting member needs.
Continue to hold district leadership meetings.
Develop events and meetings that are meaningful to encourage greater participation.

Objective 2: Identify and support peer-based teams within districts to organize education, social and other activities designed to improve the value and cohesion of the local DO community.

Strategies: Create local/regional CME programs.
Support new DOs in the communities.

(continued on next page)

Develop and ombudsman program in collaboration with APOMA to reach out to DOs in need on a local level.
 Establish mentor programs.
 Develop a generational communications strategy.
 Develop a member recognition program for member achievement, community contributions, and long-term members.



Pillar: Education

A key aspect of POMA's role is to be a leader in providing educational opportunities that incorporate clinical and non-clinical resources for students, residents and practicing physicians. This includes strong CME offerings, both online and in person, supportive resources for career tracks (solo, small/group practice, employed) and locations (urban, suburban, rural) and personal career support for physician stress, residency programs and student debt. An osteopathic workforce

that has solutions and resources to be better prepared to address these challenges will enhance POMA's strategic value proposition.

Goal: *Osteopathic physicians will provide high quality care and own viable, successful practices.*

Area: Continuing Medical Education (CME)

Objective: Provide accessible, affordable continuing medical education (CME).

Strategies: Create robust online CME designed to provide more accessible, osteopathic-specific education including state mandated education.

Expand district or institutional level CME programming to provide more accessible education and improve the local community of DOs

Investigate and implement online question series with CME credit.

Explore offering online journal club/problem-based learning programs.

Develop or partner with organizations providing instructional video on various topics such as osteopathic techniques, joint injections, etc.

Obtain the newest list of activities that qualify for CME credit.

Area: Practice Viability

Objective: Provide resources and education to improve the viability of osteopathic led practices and health institutions.

Strategies: Create online practice management education and service offerings that provide-practice leaders with critical business and leadership resources.

Investigate developing a portfolio of direct practice services (billing, EHR, legal) designed to provide POMA members with vetted, trusted and useful practice management and leadership assistance.

Develop materials/programs on practice opportunities for physicians.

Develop leadership skills courses.

Area: Residents/Career

Objective 1: Collaborate with program directors to educate residents on the distinct value of osteopathic principles and careers in osteopathic medicine.

Objective 2: Work with residency programs to pursue and maintain osteopathic recognition.

Strategies: Create orientation program designed to educate residents on the value and-desire ability of a career in osteopathic medicine.

Create a Practice 101 program designed to help residents make the transition to practice more smoothly and become productive members of a clinical team more quickly.

Area: Influence

Objective: Create education resources on the unique aspects of osteopathic principles and the value to patients and families.

Strategies: Develop educational materials for the public and public officials.

Determine target audiences for materials based on priority, then develop accordingly.

Pillar: Influence

POMA's role is to be a leader in supporting osteopathic principles and practices at the state and federal level for physicians, patients, health care systems and policy makers. Insufficient reimbursement levels and competition from non-physician clinicians are the top policy issues facing POMA members. Increasing resources in these areas is critical to POMA's success as an organization and supports the vision that patients are healthy and highly satisfied with their osteopathic medical care.



Goal: *Critical stakeholders (insurers, health systems, residents, patients and the public understand, support and advocate for osteopathic principles and practices.*

Area: Advocate

Objective 1: Inform policy makers about osteopathic principles and practices and encourage support of policies/legislation which improves care and patient access.

Strategies: Engage contact services and add staff to develop an advocacy program dedicated to POMA.

Look to the Committee on Legislation and Public Policy to determine advocacy direction and priorities.

Consider developing legislation and public policy initiatives that support POMA public policy priorities.

Develop training for POMA leaders and members to engage public officials regarding POMA's public policy and legislative priorities.

Consider hiring/engaging staff to conduct research that supports POMA policy positions.

Conduct research to define metrics of Triple Aim, cost effective care, and other issues supporting POMA priorities.

Develop infrastructure and resources to support research and data.

Objective 2: Continue efforts to improve giving to the political action committee to fund educational and other activities targeting Pennsylvania state policy makers.

Strategies: Add staff and/or other resources to develop, recruit and engage donors.
Engage districts to recruit and engage donors.

Objective 3: Expand local coordination and outreach of members to improve relationships with public officials and public and private organizations.

Strategies: Coordinate meet and greet functions within POMA districts.
Build relationships with COMS, health systems and other organizations to sponsor town hall functions and discussions with public officials.
Coordinate community events for increased visibility and awareness.
Materials developed should reflect the value of POMA/POMA membership.

Area: Leadership

Objective 1: Support physician led dialogue with health institutions on application of osteopathic principles and practices.

Objective 2: Organize members at the local/institutional level to improve education of health system management regarding clinical challenges and the application of osteopathic principles to address these challenges.

Strategies: Build relationships with COMS/Residency Program to provide in-person education on POMA, what it does and how to become involved.
Education politically engaged groups on matters of effective governance.
Develop mentor programs to engage future leaders.
Develop a formal mentor program for new board members/district leaders.

LECOM DEAN'S CORNER

Lake Erie College of Osteopathic Medicine

Reflections Upon Medicine: Contemplating the Profound Purpose of the Medical Professional



*Silvia M. Ferretti, DO
LECOM Provost,
Vice President and
Dean of Academic Affairs*

As we welcome the Christmas Season, the holiday festivities, and the coming New Year, we at LECOM also contemplate the past and present with gratitude and we welcome the future with hope and optimism.

The New Year brings with it a time for reflection and for imagining the boundless possibilities attainable in the coming months. As we turn our collars to the nip in the air or as we add a few more logs to the fire, we invite you to reflect upon the vast import of the medical profession and to contemplate its direction as we look ahead with purpose.

Turning the pages of time, those of us in the medical profession will have been met with some pivotal partners with whom we have formed meaningful alliances. Scholarship and stewardship, sacrifice and determination, have developed our skills. Students and faculty have honed our abilities and deepened our purpose, technological advances have eased our objectives, and a commitment to service and to exceptionalism has defined us.

All in all, our profession champions the mission to offer the best in healthcare, healthcare education, and the betterment of our society than does any other entity. Eventually, at one point in time or another, each person in the calling discovers that the important moments in life — the truly golden glimpses of meaning found along this journey in the medical profession are not those that are announced; not the birthdays, the holidays, the weddings, not even the great goals achieved. The true milestones are less prepossessing, for they come to the threshold of one's memories unannounced. They are the silent voices that strike within each medical professional a chord of truth, of worth, and of Providence. Each life is measured by these. As medical professionals, each life will be filled with such golden moments; a time when a patient looks to his physician with thankful eyes, when the fearful child hears the calming voice of the pharmacist, or when a crucial medical judgment proves inexpressibly fruitful for another.

With the knowledge that neither success nor failure is ever final, a wise caregiver will make more opportunities than he finds. LECOM educators and medical professionals understand that there are no shortcuts to any place that is worth going. The founders at LECOM recognize that the moments that underpin the profound purpose of the medical professional are honed through developing an inner resilience, a dynamic will, and an unyielding determination to persevere through all trials and travails with an attitude of optimism and of affirmation. It is in those moments — often quiet, sometimes filled with inner struggle, always present in the heart and mind of the goal-oriented physician, pharmacist, or dentist — that the power of those silent truths will nurture the core-felt voice that urges one forward at a point that all strength has appeared to cease.

Throughout all aspects of one's medical training and in the practice of healthcare one is called to recognize that the cause of service to others is central to finding that core-felt voice, for a genuine care for others must become as a habit, so ingrained within the human state, that it is stronger than the desire to rest. The superlative physician carries this crowning quality, the exceptional pharmacist finds it as an abiding principle, and the incomparable dental practitioner follows it as the North Star.

LECOM educators know that the fullest understanding of medical comprehension extends beyond the mastery of the training programs to the concentrated patience, to the sincere devotion to the service of others, and to the assiduous endurance in the attainment of those ends. Once one discovers those golden moments, there are few calamities that are not conquered by the experience.

Just as various occurrences and pressures of nature change sand into pearls and coal into diamonds, rigorous medical training and intensely focused demands of the curriculum transform scholars into highly-skilled medical

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Philadelphia College of Osteopathic Medicine

The future of medicine is ever-changing and ripe with possibility — as institutions that educate the health practitioners who will practice in that future, it is up to us to make sure they are as competitive as possible. We give them a good foundation in osteopathic medicine, but graduate medical education (GME) is the key step between learning medicine and practicing it.

In the very near future, our profession will fully transition into common accreditation standards under the Accreditation Council for Graduate Medical Education (ACGME), which will have lasting effects in GME and how we train future physicians. To that end, at PCOM, we have been aggressively pursuing ACGME accreditation for each of our 13 residency programs since 2015.

In October, we were very proud to report that PCOM's General Surgery Residency program received continued accreditation status from ACGME. It was the first osteopathic general surgery residency in the country to achieve this status — one that many new surgery programs have yet to achieve — and joins the Internal Medicine Residency program in reaching continued ACGME accreditation for the full 10 years.

The General Surgery Residency program received initial accreditation status in 2015, and since then, all of PCOM's residency programs have either applied for or received pre- or initial accreditation status. All of the College's residency programs will apply for osteopathic recognition.

PCOM is incredibly proud of the efforts of all of our faculty and staff who are working hard to ensure all of our programs are modified to meet the ACGME's requirements for full accreditation. Arthur Sesso, DO, professor and chair of surgery at PCOM, has been instru-

mental in our efforts to modify the General Surgery and other residency programs at the College, and has consulted for the AOA to help roughly 50 DO residency programs in various specialties all over the country achieve initial accreditation from the ACGME.

This transition to common accreditation in GME did not happen overnight; I can recall many concerned discussions some 25 years ago, when osteopathic hospitals were closing or merging. In order to ensure our students got the training they needed, we had to work collaboratively with other hospitals — many in which our students were already training. This common GME accreditation is another transition the profession must undertake to ensure that we are training highly skilled, caring and competent osteopathic physicians.

The value of GME in training the workforce of the future cannot be overstated. In fact, research has suggested that the design and location of residency programs, among other factors, could ultimately shape the kind of clinician a doctor will become — perhaps even more so than their four years in medical school.

That said, although GME can go far in shaping a physician's clinical practice, it is my belief that the osteopathic philosophy that is imbued within the first four years of medical education is sustainable throughout this transition. It provides a strong foundation of compassion and whole-person care, which speaks less to the mechanics of medicine, and more to its soul.

As we transition fully into a single accreditation system, we can work to ensure quality, consistency and efficiency of our GME programs, and elevate the profession and its unique value proposition as one that is vital to healthcare.



*Kenneth J. Veit, DO
PCOM Provost, Senior Vice
President for Academic
Affairs and Dean*

A STUDENT'S VOICE — PCOM

Justin Owens, OMS-II and Ashley Pinckney, OMS-II



*Justin Owens
PCOM OMS-II*



*Ashley Pinckney
PCOM OMS-II*

"Medicine is not what it used to be." If a dollar was given for every time these words wisped off our tongues, every clinician in the United States could pay off their remaining student debts and then some!

Needless to say, physicians have an enormous burden practicing medicine in the 21st century. From battling misinformation broadcast via social media, staying up-to-date with the latest evidence-based medicine, advocating for patients' needs while managing push-back from insurance companies, and skirting the line between responsible care and defensive medicine, many physicians are struggling to keep their heads above water. It is thus no surprise that frightening buzzwords like "burnout," "moral fatigue," and "physician suicide" frequently find their way into newsletters and journal headlines.

From the perspective of a medical student, it would appear that now is an ominous time to be pursuing a career in medicine. If medicine is not what it used to be, what is there to look forward to? This question may be answered with a candid look at some promising innovations in medicine and where they might take us as a profession. Our generation of future doctors has access to cutting-edge medical technologies, unconventional treatments for once untreatable illnesses, breakthrough developments in our understanding of the human genome and their implications in the exercise of precision, and patient-centered medicine. All of these advancements challenge what once defined clinical medicine. With talk of the "death of the stethoscope" and its replacement with ultrasound and laboratory technologies, even the expectations of how clinicians perform their histories and physical exams at the bedside have changed from what they used to be. Unfamiliar as these adjust-

ments in the delivery of healthcare may be to the lay public now, we as physicians-in-training believe a new healthcare landscape is being paved that works in the favor of responsible medicine and the patient populations it serves.

The prospect of individualized medicine is another exciting new frontier for clinical medicine. Prior to our current understanding of the role epigenetics plays in the development of pathology, patients could only be treated by general paradigms in disease. Breakthroughs across the spectrum of medical sciences have changed the course of disease treatment and informed the notion that patients may require patient-tailored, disease-specific treatment. Gene sequencing has allowed the medical community to pinpoint specific genetic abnormalities and mutations to better predict the course of disease. Instead of pursuing arduous courses of chemotherapy, patients with cancers can now be treated with immunotherapy, reprogramming their bodies own cells to fight the disease for them. New pharmaceuticals have rewritten the narrative for diseases like HIV or hepatitis C virus — taking them from a death sentence to a chronic illness. These are discoveries that physicians of previous eras spent years trying to accomplish. To our delight, their dreams have become our reality.

With all of the progress medicine has made, there is still more that can be accomplished. The demands on physicians' time today are greater than ever, but we must not forget that without our patients, we would not have a purpose. While these new technologies are available to aid in medical care, the emphasis should still remain on our beloved patients. We must not lose sight of the magnitude of trust patients extend to us while allowing us to be partners in their journey to wellness.

We Don't Need No Stinkin' Science!

Initially I thought this was going to be quite an easy assignment. I would write some facts about the opioid crisis, make a few comments about its inappropriate usage and talk about how medicine in the world would be better off.

Nothing is ever as easy as it seems. On October 30, the *Annals of Internal Medicine* published an article that stated "Firearm violence continues to be a public health crisis in the United States that requires the nation's immediate attention." The article concluded that there is a "need for a multifaceted and comprehensive approach to reducing firearm violence that is consistent with the Second Amendment."

The response from the NRA on November 7 was startling. "Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in *Annals of Internal Medicine* are pushing for gun control. Most upsetting, however, the medical community seems to have consulted no one but themselves." Hours later, 12 people lost their lives in the California bar. Gun violence has taken place in the hospitals, bars, churches, elementary schools, movie theaters, universities, nightclubs, synagogues, newsrooms and outdoor concerts.

On November 19, Mercy Hospital and Medical Center in Chicago was the scene of a mass shooting. Dead are an emergency room physician, a pharmacy resident and a young police officer married, raising three children. These were totally unnecessary deaths. Interestingly, the shooter who later shot himself, possessed his weapons legally. He was allowed to keep his weapons even after his ex-wife filed a restraining order against him. Because the order was terminated in 16 days, he did not meet the threshold for weapons removal. What is part of the future of medicine? To stand firm against organizations that endanger the lives of those we have been trained to save. I am not anti-weapons. I have fired 45s, 9mm and M-16s. I am steadfastly against gun ownership of those who are potentially dangerous. What happened at Mercy Hospital could easily have been in any hospital where we work or become a patient. No one suspects to be harmed in such institutions.

To simply write this article concerning gun violence would be a disservice. The future of medicine is also negatively affected by the

public's false interpretations of scientific data. There are those who claim that climate change is a hoax. They simply refuse to heed the vast amount of scientific evidence pointing to drastic outcomes. Unless immediate changes take place we will have a future where physicians will be treating fire, famine and flood victims routinely. What is part of the future of medicine? We must link arms with scientists pleading with our politicians for immediate and lasting industrial and environmental changes.

An additional part of the public's false interpretation of scientific data are the anti-vaxxers. Physicians once again will have to be well-versed in treating what we use to euphemistically call, usual childhood diseases (UCD). We now have well documented outbreaks of UCD's in elementary school populations and vacation areas popular with young families. Until the public is better educated we will once again deal with the ravages of healthy children who lose their hearing, suffer cognitive decline and perhaps death, all of which can easily be controlled with herd immunity. What is part of the future of medicine? To stand with the science and educate the public.

STDs are on the rise. Once again the public seems not to recognize the value of protection. We as physicians often simply do not routinely investigate for the presence of these maladies. There are those who will read this article today and remember when every patient, upon every admission, was subjected to an RPR. I am not suggesting that these days return, I am simply pointing out that our histories be more inclusive and detailed. Hopefully this will lead to better detection and treatment. It is doubtful that reliance on EHRs will benefit this cause. What is part of the future in medicine? Adherence to the past as concerns histories and physicals.

Suicide rates in the USA have been astonishing. The suicide rate has increased 33% between 1999 and 2017. 47,000 Americans committed suicide in 2017. Suicide is the second leading cause of death for Americans between the ages of 10 and 34. It is the fourth leading cause of death for middle-aged Americans. We are now witnessing an increase in "deaths of despair". These include suicides,

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Samuel J. Garloff, DO

Guest Column

Cyber Threats and Your Practice — Are You Protected?

by Amy Chamberlin

Cyber crime in this day and age is big business. Medical practices are a huge target for cyber criminals—the health records, personal identification information, and financial data you keep for your patients is like gold to nefarious hackers looking to make money if you let your guard down. It is essential that you are proactive in protecting this data, but also in being prepared for a breach should one ever occur.

One might think that large health systems and hospitals are the primary targets of hackers. This is not the case. Large health systems with dedicated IT departments and large budgets for cyber security are more difficult to hack, while small practices are often easy targets because they don't have sophisticated security measures in place. It's imperative to have policies, procedures, and safeguards in place to reduce the risk of a cyber attack.

Beyond the hassle of cleaning up after a hack, medical practices also need to be concerned about legal repercussions associated with the U.S. Department of Health and Human Services (HHS) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Hefty fines and settlements to the HHS Office for Civil Rights, which investigates breaches of protected patient health information, could financially ruin a small practice. These fines are over and above the costs associated with forensic investigations after a breach, business losses and downtime, data breach notifications to affected parties, and other lawsuits or extortion that could be involved in the attack.

So, how do these breaches happen? Unfortunately, cyber criminals are becoming more organized and sophisticated. Here are just a few examples of incidents in 2018:

- In Maine, a medical center had the FBI investigate the disappearance of an external hard drive owned and operated by an outside vendor. It included data such as names, dates

of birth, medical record numbers, and medical conditions. Worse yet, the medical center waited a month to alert patients of the possible data breach, leading to patient distrust.

- In Indiana, a ransomware attack through a hospital server using Remote Desktop Protocol caused a shutdown of the entire network, including all computers in the hospital, physician offices, and wellness centers. Providers were forced to use pen and paper for charting, as the electronic medical record (EMR) system was not available, and it took two full days for the systems to go back online after paying a \$55,000 ransom.

- In West Virginia, the protected health information (PHI) of more than 43,000 patients was potentially exposed because of the theft of an employee's unencrypted laptop from their car. Luckily, the laptop was protected with various security measures; however, criminals are becoming more adept at bypassing password protection and other security measures. The data was not ultimately breached; however, the health system had to revamp its security policies and procedures to reduce the risk of a similar incident in the future.

By now you're probably thinking that you should take a closer look at your IT systems and security measures. Indeed, this should be your highest priority, to protect both your patients, and your practice. But you don't need to tackle this alone. One online resource that's a good place for information is the *HIPAA Journal*: www.hipaajournal.com. Here you can find useful articles about healthcare data privacy, data security and cyber security. There are also resources including a HIPAA risk assessment, HIPAA encryption requirements, email compliance, certification, and common HIPAA violations. You can also download a free simple guidelines HIPAA compliance checklist from the site to get you on the right path.

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Medical Update

The Use and Effectiveness of Texting in Healthcare: A Survey of Medical Professionals

Introduction

Text messaging has taken the world by storm and has become one of the main forms of communication. As of 2011, 73 percent of Americans send texts messages on a regular basis as a form of communication.¹ Sending and the receipt of text messages has the advantage over phone calls by allowing two users to communicate in a way that does not require them to be both available at the same time. This is a very useful tool for people who are busy that need to get quick messages to each other with only minimal interruption of their activities.

Traditionally thought as a young adult form of social interaction, texting has extended to other age groups and beyond social circles. It is now being used in the work place and healthcare is no exception with doctors joining in as quickly as other healthcare professionals. In one poll 72 percent of physicians use texting as a form of communication with one another.² There are incredible benefits with texting between physicians as it is instantaneous, direct and convenient way for busy physicians to get a message to one another. It reduces time waiting for colleagues to call back and frees the waiting physician to continue working while waiting for a response, which might expedite patient care.³

While there are many benefits that have justified adoption among physicians, it isn't without potential hazards. The first and foremost potential hazard is the protection of patient health information. The Health Insurance Portability and Accountability Act (HIPAA) has established rules that limit what can and cannot be sent via text messaging. With penalties of up to \$50,000 per violation, safeguarding what is sent and received through text messaging should be a high priority for physicians.

Evolution of Telecommunication

Telecommunication has been an essential tool of the human race that dates back to the prehistoric era where drums, fires, bea-

cons, smoke signals and horns were used for communication. In the modern day era, semaphore systems emerged in Europe in 1790 which used towers with pivoting shutters to communicate with other towers.⁴ The advent of electrical telecommunication systems first started to appear in 1809 with the telegraph created by a German physician Samuel Thomas von Sommerring.⁵ His design required multiple wires and acid to convey a message. Recipients would observe the wires that went into the receiving acid that would bubble when a message would come in and record the message according to the order of bubbles coming from the acid.

Later would come the telephone from which the world would never look back. Alexander Graham Bell is considered the father of the telephone with its introduction to the world in the 1870s. All patents for the electric telephone and features flowed from the master patent of Alexander Bell that would eventually become an essential part of every family.⁴

From the original wired telephones that was in every home came wireless mobile phones that are now in every pocket. Mobile phones have become a personal item with a number that is unique to each individual allowing a caller to reach a specific person. This would set the stage for Short Message Service (SMS) which is a modern day version of what Samuel Thomas von Sommerring did in 1809, sending words from one device to another.

Text messaging has grown rapidly worldwide and especially in America. It is now estimated that over 4.8 billion people in the world own a mobile phone according to the Mobile Marketing Association of Asia while only 4.2 billion people own a toothbrush.⁶ In PewResearch survey in 2015, 91 percent of Americans own a cell phone and 80 percent of them send and receive text messages on a regular basis. The majority of those that text are between the ages of 18 and 24 whom send

by Steven G.
Ward, DO, MS

an average 110 text messages a day, or 3,200 messages per month.⁷ Text messaging has been growing exponentially over the last 10 years. From 2007 to 2010 the rate of text messaging tripled with an estimated 6 trillion messages sent in 2010.⁸ Texting is threatening to become the main mode of communication with an average American exchanging twice as many texts as they do calls.⁹

Texting in Healthcare

Healthcare professionals are embracing texting at nearly the same rate as the general public. A survey conducted in 2011 found that at the time, 73 percent of the general population was texting while 72 percent of physicians were texting each other about work.²

Beyond the familiarity of texting from their personal lives, physicians find benefits of texting that have improved communication within their practice. It is the fastest and most efficient way of sending information in given situations that involve factors such as background noise, poor wireless network coverage, lack of a computer available, and multiple emails diluting their inboxes.¹⁰ The efficiency of text messages are well documented. It has been shown that 90 percent of text messages are read within three minutes of their delivery. Over 97 percent of text messages are opened, while only 22 percent of emails are opened. The average person responds to a text message in 90 seconds, compared to 90 minutes for an email.¹¹

Texting may improve communication between physicians which might also improve healthcare. The 2011 Joint Commission sentinel event report identified poor communication as the number one cause of delays of patient treatment, as well as the second leading cause of operative and postoperative complications.⁶ Traditionally, contacting a physician has been facilitated by beeper and telephone systems. This has been linked to delays in response time and interruption that may compromise patient care.¹² Text messages allows for immediate delivery of the message to the recipient as well as immediate response which can be crucial when life saving measures are time dependent.

HIPAA Compliance

Texting is not against HIPAA regulations, if it used correctly. Whether it is compliant or not depends on who the message is being sent to, the content of the message (does it contain protected health information (PHI)),

and the mechanisms put into place to protect the information.

HIPAA Security Rules have been established to help guide users on whether they are being compliant or not.

- Access to PHI must be limited to authorized users who require the information to do their jobs.

- A system must be implemented to monitor the activity of authorized users when accessing PHI.

- Those with authorization to access PHI must authenticate their identities with a unique, centrally-issued username and PIN.

- Policies and procedures must be introduced to prevent PHI from being inappropriately altered or destroyed.

- Data transmitted beyond an organization's internal firewall should be encrypted to make it unusable if it is intercepted in transit.¹³

Standard text messaging often fails on all of these accounts listed above. Ways of violation is that the message could be sent to the wrong number, forwarded to another recipient, or intercepted while in transit.¹³

Method

The objective of this study was to evaluate the way healthcare professionals use text messaging in their jobs, the benefits they see from it, their knowledge of rules and restrictions, and how they see the future of text messaging in healthcare. A survey of 10 questions was created using Survey Monkey and distributed to members of LECOM and its consortium through a mass email. IRB exemption was obtained from LECOM prior to collection of the data. Participants voluntarily did the survey, which was completely anonymous. No identifiers of participants were identified including Internet Protocol (IP) addresses. After a span of 30 days, data was collected via Survey Monkey from 81 participants that included physicians, mid-level providers, nurses, nursing assistants, and non-patient contact workers who work in healthcare.

Results

There were 61 (75.31 percent) doctors, 4 (4.9 percent) mid-levels, 7 (8.6 percent) nurses, 2 (2.5 percent) nursing assistants, and 7 (8.6 percent) other category who took the survey. Of those that took the survey 71 (87.7 percent) use an iPhone, 9 (11.1 percent) use a Samsung smart phone, and 1 (1.2 percent) use a phone in the other category. No persons use a Microsoft, Blackberry, or LG phone. Doctors use an

iPhone 85.3 percent of the time with Samsung at 13.1 percent of the time.

In terms of securing their smart phone, 97.5 percent secured their smart phone in some manner. A security code was used 82.7 percent of the time, 75.3 percent of phones had a finger print sensor. No smart phone was secured with retina scanner, facial recognition, or any other way.

Of the 81 participants, only 7 (8.6 percent) have not sent some kind of patient information via texts. Of those 7 who have not sent any patient information, 3 (4.9 percent of total) were doctors, 2 (28 percent of total) were nurses and two mid-level and other category (14 percent). Doctors sent the most patient information with patient location (85.3 percent) and patient diagnosis (83.6 percent) being the most commonly sent patient information. Patients name had been sent by 67.2 percent of doctors surveyed. Photo of X-ray (78.7 percent), photo of patient body part (68.9 percent) and history of the patient (78.7 percent) was also sent by doctors.

Texting was used as a mode of "sign out" by 51.7 percent of doctors with 74.2 percent of them feeling that it is an adequate and helpful way of signing out. Of the 48.3 percent of doctors that don't use texting as a mode of "sign out", the most common reason for not doing so was 70 percent feel that it is not an adequate way to sign out, only 10 percent did not do it because it was against the rules.

Sending pictures by text was regarded highly among doctors with 85.3 percent of them feeling that is very helpful with only 3 percent not feeling that it is helpful and 4.9 percent feeling that it is not necessary. 6.5 percent did not do it because it was against the rules.

Familiarization with facility rules had doctors at 60 percent not knowing what the rules were. 8.3 percent replied that they do know the rules and that it is allowed, 18.1 percent replied that it is only allowed through a secured third party app, 6.7 percent it is not allowed, and 6.7 percent did not have a policy.

When questioned whether there have been communication errors that resulted in patient harm, no participant reported any miscommunication that resulted in a sentinel event. A misunderstanding was corrected with additional texting in 18 percent of respondents, corrected with a phone call with 22.9 percent, and 59 percent of participants have not had any communication issues through texting other healthcare providers concerning patient care.

Using texting as a method to refer back to for patient care, 73.3 percent of doctors found

that it was useful to have available, 10 percent use it as their main method of rounding on patients and 26.7 percent feeling that it is not necessary.

Finally, with regard to the future of text messaging in healthcare 54.1 percent of doctors surveyed felt that texting is the way of the future and main form of communication. 44.3 percent felt that is useful now but will adapt to other forms of communication and only 1 percent of participants feel that it is a fad and will likely wear off.

Discussion

Texting

Behavior

All groups of healthcare professionals surveyed sent at least one form of patient healthcare information. Doctors had the highest

percentages of sending patient information. Patient location and diagnosis was the most commonly sent pieces of information with doctors sending it at 85.3 and 83.6 percent, respectively. Clinical pictures of the actual patient and X-rays were also sent commonly among physicians at 68.9 and 78.7 percent respectively. As will be discussed below, sending pictures is a highly valued part of messaging between physicians and they overwhelmingly find it useful. All forms discussed up to this point can be done without violation of HIPAA policy, as long as patient identifiers are not included. When patient identifiers are included, as in the patients name, which was sent 67.2 percent of the time, or patient history that can be linked to the patient, the data must be encrypted and follow the guidelines as outlined in the HIPAA Security Rules.

Most physicians claim to not have had an experience with poor communication when texting, 59 percent stating they have no issue. Of those that have experienced poor communication, 23 percent cleared up the communication with a phone call while 18 percent cleared it up with additional texting. No physician, or any other healthcare provider, stated that they had a sentinel event that resulted in harm to a patient related to poor communication through texting.

Many of the physicians found that having the texts with the history sent is a valuable re-

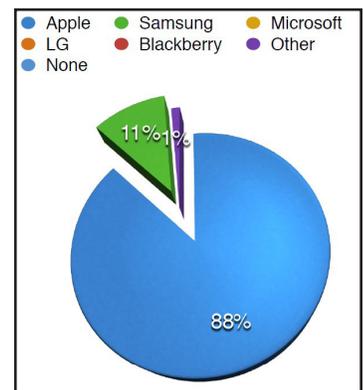


Figure 1: Types of smart phones used by healthcare professionals.

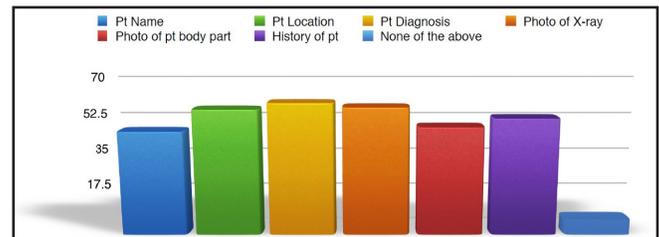


Figure 2: Type of patient healthcare information shared with other healthcare professionals.

source to refer back to when needed. All of the physicians surveyed owned a smart phone. Of all US mobile users 91 percent keep their phones within arms reach at all times.¹¹ This behavior makes having the list of patient or patient information along with them at all times very useful. Printing a patient list out to keep track of information is arguably less secure as it can be left out for others to see, is not secured by password or other security settings, can be easily lost, and requires disposal in a proper receptacle that is not always readily available.

Pictures

Different healthcare professionals were asked to describe the ankle fracture in the image during this study, the responses varied and seemed to paint a different picture.

All of the healthcare professionals mentioned that there is an ankle fracture, but beyond that the description changes. The orthopedic residents both mention that there is a fracture dislocation, but only the senior resident mentions that there is diastasis of the syndesmosis which is important for treatment. The ER physician mentions the type of fibula fracture but incorrectly states that the dislocation is posterior.

Where the descriptions vary from the different healthcare professionals, a picture says it all. By looking at the picture, the treating surgeon knows the urgency of the reduction, has a general idea of the size of the patient, understands how distal the fracture of the fibula is, has an idea of what type of implant needed for fixation, realizes the need for repair of the syndesmosis, and can generally make a full plan of care where he would likely not be able to do so as comprehensively as compared with a description of it from differing providers.



"There is an ankle fracture, spiral fibula fracture, posterior dislocated."

- ER Physician

"Right ankle fracture dislocation, laterally dislocated with an oblique distal fibula fracture."

- Junior orthopedic resident

"Right bi-mal equivalent ankle fracture-dislocation with lateral displacement and syndesmotic diastasis."

- Senior orthopedic resident

"There is a mildly comminuted long oblique fracture of the distal fibula present, there is complete dislocation of the tibia and fibula relative to the talus. There is at least 5cm of offset."

- Radiologist

Figure 3: Description of an ankle fracture sent via text message to different healthcare professionals.

In this survey, doctors valued pictures extremely high with 85.3 percent of them feeling that pictures are very helpful way of communicating and only 3 percent feeling that it is not helpful.

Conclusion

Texting in healthcare has benefits of being an efficient and expeditious way of communicating with other physicians. The majority of physicians surveyed believed that not only is it an effective and helpful tool today, but it is the way of the future in healthcare communication. Physicians felt that sending clinical pictures or X-rays of patients was very beneficial and helpful when trying to communicate.

Problems may lie in complying with HIPAA while sending text messages about patient information. Texting can be in complete compliance with HIPAA as long specific guidelines are met. Physicians and healthcare administrators must be aware of the rules and regulations and do what is required to protect patient health information.

Texting is an efficient way of communicating inside and outside of the hospital. Healthcare professionals can learn to use it as an effective tool to help them be more efficient and care for patients in a safe and secure manner.

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Medical Update

Osteopathic Manipulative Medicine in Sports Medicine: A Survey Gauging Attitudes and Its Incorporation into Practice by Sports Medicine Physicians

Introduction

Manual therapeutic treatment plays an integral role in sports medicine. However, sparse Osteopathic research has been completed outlining the facility of Osteopathic Manipulative Medicine (OMM) in the sports setting. Osteopathic principles stress the symbiotic relationship of form and function fit well in the premise of sports medicine and should be further investigated. No research currently available has adequately described the use of OMM in sports medicine, as well as the attitudes towards these techniques and philosophies by sports medicine physicians. The researchers hypothesized that sports medicine physicians trained at osteopathic post-graduate programs will see OMM in a favorable light and be more prone to incorporate it into their daily practice. This investigation is designed to draw attention to the prevalence of osteopathic principles and OMM in the sports medicine arena. The examination of OMM in sports can also provide further evidence of how osteopathic principles can improve medical practice in a general sense.

Background

The use of manual manipulative techniques within the sports medicine realm is broad and well accepted. While Chiropractic therapies are the most visible and researched in sports medicine, Osteopathic Manual Medicine (OMM) has recently emerged in popularity. Osteopathic Medicine is rooted in the teachings of Dr. A.T. Still. He developed osteopathy at the end of the 19th century in response to the medical practice of the day that he viewed

as detrimental to the innate healing processes of the body. Dr. Still taught that physicians armed with thorough knowledge of anatomy and physiology can use their hands to aid the body in recovering from illness and mechanical derangement.¹ Even today, the D.O. (Doctor of Osteopathic Medicine) physician is meticulously trained in Dr. Still's four general principles: 1.) The body is a unit; the person a unit of body, mind, and spirit, 2.) the body is capable of self regulation, self healing, and health maintenance, 3.) structure and function are reciprocally interrelated, and 4.) rational treatment is based on an understanding of the above three principles.¹ Osteopathic medicine combines the modern day advances in medical technology and knowledge with Dr. Still's philosophies about manual medicine's power to enhance the body's innate homeostatic and protective mechanisms. Whereas the Chiropractic approach focuses on improving the neurotransmission of the nervous system via adjustments of the vertebral spine, osteopathic medicine centers treatment upon optimization of blood flow for maintenance and restoration of health.²

Manual therapy has a very integral role in sports medicine. It is intuitive, that manual manipulative therapies directed at the neuromuscular system will have physiologic and biomechanic benefit in the athlete.³ The athlete's neuromuscular organ system is pushed to the limit with requirements of biomechanical strength and flexibility, as well as gravitational demands. The sports medicine physician's role is to "identify dysfunctional patterns and seek to guide our athletic patients

*by James N.
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in neuromusculoskeletal behavioral patterns that are less costly biomechanically and more favorable to health and efficient functioning.^{7,4} Osteopathic principles that stress the symbiotic relationship of form and function fit well in the premise of sports medicine, especially therapies that aim to return pain-free form and function, prevent injury, and even enhance sport performance. Nonetheless, very little significant Osteopathic research has been completed outlining the facility of Osteopathic Manipulative Treatment (OMT) in the sports setting.

Manual medicine can maximize pain-free movement of the musculoskeletal system, enhance neuromuscular functionality, and improve biomechanical balance, all of which are paramount for an athlete to perform at their highest ability. Evidence-based research has been performed showing the benefits of osteopathic manipulative techniques in treating a variety of musculoskeletal problems. OMT has been shown to reduce back pain.^{5,6} Chiropractic manual techniques such as high velocity, low amplitude techniques (close kin to the Osteopathic version) has been shown to improve hip joint extension in male athletes that were suffering from hypertonic hip flexors improving overall agility, power, speed and reaction time.⁷ Spinal manipulative therapy plus a prescribed stretching program improved the full-swing performance of a group of golfers compared to a group that was prescribed the stretching program only. Electromyography was used to assess the core strength of both groups showing improved strength in the spinal manipulative therapy plus stretching group.⁸ An Australian randomized control trial claimed improved prevention of back pain, hamstring and lower limb injuries in a group of semi-elite rugby players that received chiropractic manual therapy.⁹

There is sparse Osteopathic-driven research in the field of sports. Bolin outlined common pediatric sports injuries that can be treated with various types of osteopathic manipulation.¹⁰ Other studies have discussed specific OMT techniques that should be used with particular sports injuries, including iliotibial band dysfunction, improvement of rehabilitation post ACL reconstruction, and sacroiliac joint dysfunction.¹¹⁻¹³ Dr. P. Gunnar Brolinson, a sports medicine osteopathic physician from VCOM has presented the most evidence connecting the facility of OMT in sports. Brolinson investigated how pre-competition OMT had a positive correlation with improved performance in Virginia Tech football players

over two consecutive football seasons.¹⁴ In 2013, researchers discussed how preventive OMT to maintain optimal structural function, can reduce stress fractures among collegiate cross-country athletes.¹⁵

Other research projects, that the authors are aware of, that discusses the utility of OMT in the sports medicine arena that have not been officially published in a journal*. These include a project performed by Copolla et al that explored pre-competitive OMT's effect upon perceived athletic performance, use of analgesics, overall pain levels and attitudes towards OMT itself in a NCAA Division I Men's Hockey Team.¹⁶ Their study highlighted the effectiveness of OMT and how it may positively influence performance as well as pain relief in an athlete. While not statistically significant, the researchers were able to show correlation of Division I collegiate athletes responding well to pre-competitive OMT through decreased analgesic use, improved pain levels and perceived improvement of game performance. Cornwell et al performed a project that attempted to describe how OMT could improve musculoskeletal movement, function and symmetry as measured by the Functional Movement Screen™.¹⁷ The Functional Movement Screen™ is an objective assessment tool designed to evaluate function in athletes by taking them through several different series of movement assessing optimal functional movement that might be deterred by limitations or symmetry. Despite being a small sample size and not having statistical significance, there was improvement of functional movement screen scores of those that received a directed OMT treatment versus the study participants that received a sham manipulation treatment. Another unpublished study brought to the researchers attention after initiation this project explored OMT's prevalence in the sports arena. Clearfield et al sent out surveys to sports medicine practitioners that are American Osteopathic Association (AOA) and American Osteopathic Association of Sports Medicine (AOASM).¹⁸ This cross sectional survey demonstrated correlation between post-graduate training and frequency of use of OMT in sports medicine practices.

Methods

Surveys designed to assess attitudes of OMM and its daily use in practice were sent to active and practicing sports medicine physicians that are members of the American Osteopathic Association of Sports Medicine (AOASM). The online surveys will gauge

several factors, including: type of training (osteopathic versus allopathic), scope of sports medicine practice, frequency of OMT use, most common injuries OMT is used for, and attitudes towards OMT's facility in sports medicine. The survey was generated to be completely anonymous and was generated on the SurveyMonkey website. Upon Institutional Review Board approval, a general email to the members of the AOASM was sent inviting them to participate by clicking on a link to the online accessible SurveyMonkey survey. Inferential and descriptive statistical analysis was performed on the received data.

Results

After two total months of data collection, 13 surveys were completed online. One survey was not completed in its entirety. Nine versus four respondents completed an osteopathic or allopathic residency respectively. Ten respondents completed an osteopathic Sports Medicine Fellowship. The remaining 3 completed an osteopathic and no fellowship training (2 and 1, respectively).

As illustrated by Figure 1, eight (61 percent) of the respondents indicated that they use OMT in their daily practice. Weekly and monthly OMT use was recorded by two participants each. Figure 2 portrays the percentage of OMT usage in the total treatment plan of the athlete. All participants indicated that OMT plays at least a small part of their overall treatment plans.

The most commonly treated body region indicated by participants is the cervical/thoracic/lumbar spine (77 percent) as depicted in Figure 3. Upper extremity and lower extremity injuries are 15 percent and 8 percent, respectively. Figures 4 and 5 portray the second and third most commonly treated body regions by OMT. Participants designated upper and lower extremity (46 percent and 50 percent) body regions concentrated on with OMT.

Figures 6 and 7 are telling of the attitudes of participants toward the use of OMT in sports medicine. In Figure 6, 75 percent of sports medicine physicians indicate that they are Very Favorable towards the use of OMT in sports medicine. This corresponds nicely to the number of sports medicine physicians that were osteopathically trained (Figures 1 and 2). Figure 7, shows that perception of OMT of patients is favorable or very favorable with over 84 percent of the total responses.

There are obvious limitations to this investigation. The number one limitation being the very small sample size. Despite our efforts to

poll a large number of sports medicine physicians, the response to our survey was abysmal. Another limitation would be the lack of involvement of allopathic trained physicians. Osteopathic-trained sports medicine physicians represent a small percentage of the total sports medicine physicians in this country. Efforts to poll physicians from allopathic sports medicine organizations would be a step that would improve this study's validity. Despite its limitations, this study has strengths as it shows that OMT is used and viewed as a favorable treatment option in the sports medicine arena.

Discussion

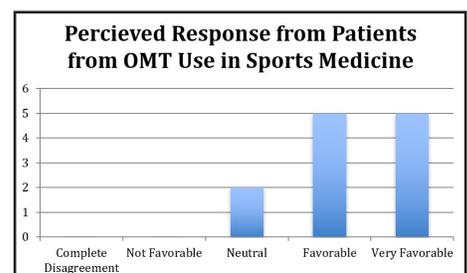
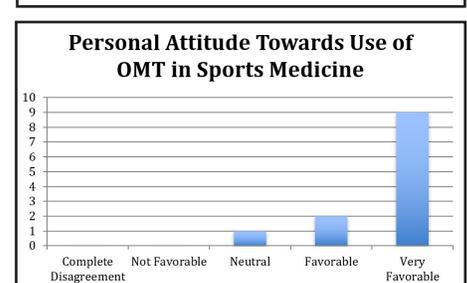
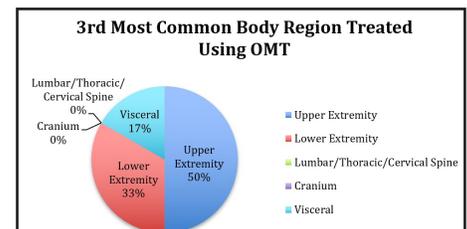
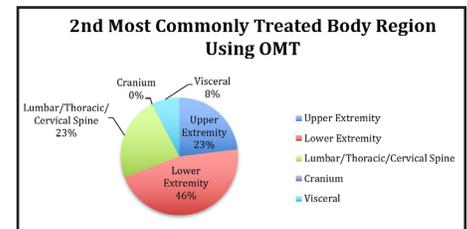
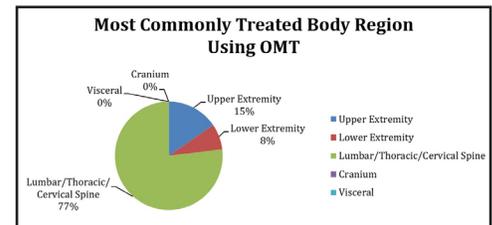
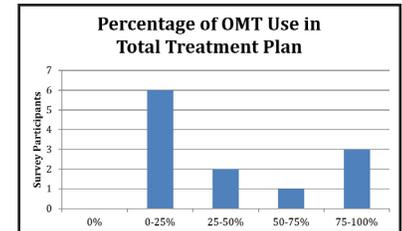
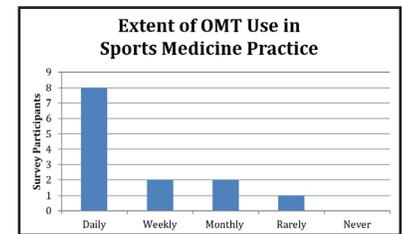
OMT's facility in the diagnosis and treatment of musculoskeletal or sports injuries is perceived as vital to the sports medicine physician. As response to this survey, John Biery, DO, stated in email that, "if I didn't have OMT as a method for diagnosis and treatment, I'm not sure how I could do sports medicine. In fact I'm not sure how I could practice medicine. It is an absolute essential part of my practice."¹⁹

Despite its widespread use in sports medicine, OMT has had little viable and reproducible research that identifies its role in sports. Describing OMM's function and facility in sports can shed more light on Osteopathic Medicine's impact. A literature review reveals little research along these lines in the osteopathic world; therefore this type of research can be very significant and serve as a springboard for other research of this nature.

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Figures 1-7, top to bottom.



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LECOM DEAN'S CORNER *(continued from page 10)*

professionals. Those medical professionals carry forth their training and expertise into the arena of need — into communities and neighborhoods — locally, regionally, and nationally.

As we reflect upon medicine and as we contemplate the important purpose of the medical professional, let us not forget that this contri-

bution, by LECOM, and by its indefatigable amalgam of healthcare affiliates, magnifies the profound and time-honored philosophy of medicine: a milestone, a monument, a magisterial achievement rightly regarded as the most comprehensive health care of our age.

OUT OF MY MIND *(continued from page 13)*

alcoholism, drug overdoses, often coupled with problematic relationships, poor health or unemployment and financial difficulties. This is in part responsible for a more shocking statistic. Life expectancy in the US has declined every year for the last three years. The last time this happened in our nations' history was between the years 1915 and 1918. What is part of the future in medicine? We as a profession must use our knowledge and time spent with patients to more fully understand their problems holistically. Then, we will be more able to direct their care.

The future of medicine demands that we become more attentive to our patients. We need to understand their histories better. This will help us determine the best usages of our physical examinations. We need to ask questions which at times may make us feel

awkward. Questions about drug use, alcohol use, financial problems, depression, relationship problems, and the ownership of weapons need to be part of our routine history taking. It honestly is no more difficult than asking about tobacco usage. We also need to join forces, stepping out of our comfort zones and speaking truth to power. Political and economic changes need to be made and they need to be made quickly. Truly the future of the world needs to be addressed. Why not by us? We also must demand of our organizations both at the state and national level to educate the public and refute misconceptions of science.

Easy? No. Necessary? Yes. Our future must pay homage to our past. We are the holistic practitioners. We must always be mindful to practice OSTEOPATHIC medicine.

CYBER THREATS *(continued from page 14)*

It's also important to work with a knowledgeable risk management professional who can guide you through the intricacies of cyber protection and insurance options. The Glatfelter Agency is pleased to be part of POMA's benefits program along with ISMIE and we are here to help support and protect you and your practice. Don't let the cyber criminals take advantage of you or your valuable patient information. Be proactive, and have a plan in place should a breach affect your practice.

Amy Chamberlin (717-852-8000; achamberlin@tga-ins.com) is an Account Executive at The Glatfelter Agency (TGA), a full-service insurance agency in York, Pennsylvania. TGA can support you and your practice with medical malpractice insurance, including the newly launched POMA/ISMIE/TGA affinity program (www.ismie.com/poma), business insurance, employment practices liability, and cyber insurance.

TEXTING IN HEALTHCARE (continued from page 15)

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PART 2A — REGISTRATION TYPE

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This course provides an opportunity to refresh your skills in foreign body airway obstruction and CPR for victims of all ages plus the use of an AED, all in an American Heart Association course led by AHA-certified instructors. Course materials will be sent by April 15, 2019 (pocket mask will be distributed during the course). Course is limited to 60 participants. Participants MUST be registered for the Clinical Assembly.

Yes, I would like to register for the BLS for Physicians course..... \$75

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- Friday Product Theater Luncheon
- Friday Evening President's Reception & Banquet (2 tickets)
- Saturday Product Theater Luncheon

I PLAN TO ATTEND

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REGISTRATION FEE TOTAL: _____ POMA OFFICE USE ONLY: CHECK NO. _____ AMOUNT _____

Note, all registrations will be reviewed for accuracy and completeness by POMA prior to approval. A \$75 processing fee will be deducted on cancellations received before April 1, 2019; a \$100 processing fee will be deducted on cancellations between April 1 - April 21, 2019. NO REFUNDS will be given AFTER April 21. A grievance policy is included in the Clinical Assembly program booklet.

HOTEL RESERVATION INFORMATION

The Radisson Valley Forge and Valley Forge Event Center has two hotels - The Radisson Hotel and The Casino Tower which are connected with interior hall access. Guest room accommodations are available between April 30 - May 3, 2019. Online reservations can be made at <http://bit.ly/POMA19CasinoTowerBlock> or <http://bit.ly/POMA19RadissonBlock>.



45TH ANNUAL POMA CLINICAL WRITING CONTEST NOW OPEN!

First Prize: \$1,000 and Golden Quill Award

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Deadline for Submitting Papers: March 1, 2019

Contest Rules & Regulations

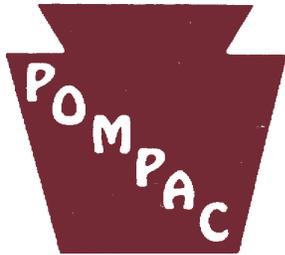
- Contest open to all osteopathic students attending a Pennsylvania COM and all osteopathic interns/residents training in Pennsylvania.
- Eligible entries **must** be research based, NOT case reports.
- Length of entries: 2,000 to 4,000 words. Articles under 2,000 words will not be eligible.
- The author's DME and/or residency program director must sign off on all papers for appropriateness of submission. Students may have the Dean or his/her designee (including a mentor) sign off on their submission.
- Each entrant must supply a photograph of himself/herself, a short biography and and two questions for the CME quiz with entry.
- Entrants should see the guidelines for original articles as specified in *The Journal's* "Information for Contributors," which appears on page 26 of this issue.
- Articles previously published in other journals are not eligible.

Submit entries to:
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CME Quiz

Name _____

AOA # _____

1. Despite the similar goals and principles of sports medicine and osteopathic medicine, there is little research that describes their symbiotic relationship.

True False

2. Recent literature of manual manipulation and its incorporation into sports medicine has shown the following:

a. Reduction of stress fracture and injury in collegiate cross country runners.

b. Improvement of the full swing performance of golfers.

c. Perceived performance enhancement in Division I football players who receive pre-competition manipulation.

d. Improved prevention of back pain, hamstring and lower limb injuries in a group of semi-elite rugby players.

e. All of the above

3. OMT has had little viable and reproducible research that identifies its role in sports medicine.

True False

4. Manual medicine can maximize pain-free movement of the musculoskeletal system, enhance neuromuscular functionality and improve biomechanical balance, all of which are important for an athlete to perform at their highest ability.

True False

To apply for CME credit, answer the following questions and return the completed page to the POMA Central Office, 1330 Eisenhower Boulevard, Harrisburg, PA 17111-2395; fax (717) 939-7255; e-mail cme@poma.org. Upon receipt and a passing score of the quiz, we will forward 0.5 Category 2-B AOA CME credits to the AOA CME Department and record them in the POMA CME module.

Answers to Last Issue's CME Quiz

1. c
2. False
3. c
4. b

(Questions appeared
in the September 2018
Journal.)

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