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September 2016

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September 2016 / Vol. 60, No. 3

THE Journal OF THE PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

The Journal of the Pennsylvania Osteopathic Medical Association *(ISSN 0479-9534) is published four (4) times a year, in March, June, September and December, as the official publication of the Pennsylvania Osteopathic Medical Association, Inc., 1330 Eisenhower Boulevard, Harrisburg, PA 17111-2395. Subscription $20 per year, included in membership dues. Periodicals postage paid at Harrisburg, PA, and additional mailing offices. All original papers and other correspondence should be directed to the editor at the above address. Telephone (717) 939-9318 or, toll-free in Pennsylvania, (800) 544-7662. POSTMASTER: Send address changes to* ***The Journal of the Pennsylvania Osteopathic Medical Association****, 1330 Eisenhower Boulevard, Harrisburg, PA 17111-2395.*

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FROM THE EDITOR'S DESK

Alice J. Zal, D.O., F.A.C.O.F.P.

Alice J. Zal, D.O.
Editor-in-Chief

At what age have you considered retiring? What have you planned for your future? Have you been putting away enough money on a regular basis so you are financially ready for that day? What else are you doing to plan for your "golden years?" These are just a few of the questions that you should be asking yourself.

There are many groups that have seminars on financial planning, and there are numerous books published on the topic. However, there is a lot more that you can do to make yourself ready to retire. My husband recently published a book about just this. It is entitled *A Psychiatrist's Guide to Successful Retirement and Aging: Coping with Change* by H. Michael Zal, D.O.,F.A.C.N., F.A.P.A. In this book, he explores planning for retirement and how to overcome the obstacles while maneuvering through these unchartered waters.

Do you have any goals you have put off? Have you deferred plans that you will "do some day?" I know I did.

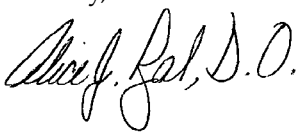
I also know that I set an age when I would retire. When I got to that age, I wasn't ready to give up my practice. However, I did not want to be one of those doctors who died in their office. Two years later, I decided to sell my practice and work part-time in a hospital-owned practice. Make certain that you fully explore your practice options and that you sit down and discuss philosophies with the people with whom you will be practicing. It's difficult to give up autonomy. It's difficult to take directions from office staff when you are used to telling them how you want things done. You really have to have a discussion with your inner self about all of these foreign concepts that you never considered before you release the reigns of control.

Just because a person retires from their practice doesn't mean they have to retire their medical knowledge. If you get bored with your to-do list, you can always do locum tenens work at your own pace. You can volunteer at local schools, teach, do research or be a physician on a cruise ship. You just have to widen your horizons and look around.

While you are doing these things, you can get more involved in the political arena of medicine. Right now, we are actively watching Senate Bill 717, which would expand the role of CRNPs; and the Interstate Medical Licensure Compact (House Bill 1619), which is a major problem for POMA since we have stricter requirements than other states. And other legislative items are constantly on the horizon.

At this point, congratulations are in order for Dr. Veit for receiving the American Osteopathic Association (AOA) Presidential Citation for dedication to patient care and his commitment to training the next generation of osteopathic physicians. Also, Dr. Gelb was re-elected to the AOA board of trustees for an additional three-year term. As always, POMA was well-represented at the AOA House of Delegates meeting in Chicago, Illinois, by 46 physician delegates, two student delegates, 14 physician alternates and two student alternates. The delegation was headed by our president, Anthony E. DiMarco, D.O.

Fraternally,



INFO FOR CONTRIBUTORS

What to Submit

Articles relating to osteopathic medicine in either the clinical or scientific area are welcomed. Articles should either document an osteopathic contribution in these areas or contribute to the education of the osteopathic physician. All articles will be reviewed by consultant(s) in the proper field and will be subject to a careful editing process. Interns, residents and fellows should include their trainer(s) as author(s). If the trainee is the sole author and wishes the paper to be published in his/her name only, a letter indicating the trainer's release of the paper from his/her department must accompany the manuscript.

Articles dealing with management problems, current legislation or regulation and similar topics will also be considered for publication. Such articles must be original work.

A short biography (C.V. acceptable), photograph of the author(s) and, in the case of medical articles, three questions (i.e., multiple choice, true/false) pertaining to the article for use in *The Journal's* "CME Quiz" feature should accompany the manuscript.

Types of Articles

Original articles — Original articles present information that is new and important to osteopathic medicine. They may document clinical material, applied research or laboratory research. Article length may range from 2,000 to 4,000 words (approximately 8 to 16 typewritten pages).

Clinical reports — These include case reports and brief descriptions of new techniques, equipment or research. They usually range from 1,000 to 2,000 words. Since they do not require abstracts, a final paragraph should provide a summary.

Reviews — Reviews are comprehensive surveys that synthesize established ideas and develop new ones. They may deal with clinical, investigational or basic science subjects. Length may vary from 3,000 to 5,000 words (12 to 20 typewritten pages).

Special articles — Articles that do not fall into the above categories (i.e., those on history, demographics, education) will be considered for publication as feature articles.

Manuscripts

Authors are encouraged to submit manuscripts via e-mail to *publ@poma.org*. Papers may also be submitted by regular mail. Manuscripts sent by e-mail should be sent as an attachment in .doc, .wpd or .rtf format. Papers submitted by regular mail should be typed in double spacing on 8-1/2" x 11" white paper, one side only, preferably with one-inch margins all around the page. Each page should be numbered. To facilitate the editorial process, authors who submit papers via regular mail are asked to include an original manuscript, one photocopy and a clearly labeled IBM-compatible 3.5" disk or CD-ROM containing an electronic version of the text in one of the above formats. Any electronic artwork pertaining to the article should be saved on the disk as a separate file.

The manuscript should include:

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- abbreviated title;
- abstract, if applicable;
- text;
- references.

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References should be typed, double-spaced, on a separate sheet. All references listed should be cited in superscript throughout the text. They should be numbered in the sequence in which they first appear in the text, listing each one only once.

Examples of properly listed references follow:

Journal reference — List the author's name, article title, journal name as abbreviated in *Index Medicus*, year, volume number, page number(s).

Example — Davidson C, Burkinshaw L, McLachlan MSF, et al: Effect of long-term diuretic treatment on body potassium in heart disease. *Lancet* 1976;2:1044.

Book reference — List the author's name, book title, location and name of publisher, year of publication. Exact page numbers are required for direct quotes.

Example — Fudenberg HH, Stites DP, Caldwell JL, et al: *Basic and Clinical Immunology*, ed 2. Los Altos, California, Lange Medical Publications, 1978.

Book chapter reference — List the author's name, chapter heading, editor's name, book title, location and name of publisher, year of publication and page number(s).

Example — Elias M, Elias P: Motivation and activity, in Birren JE, Schaie KE (eds): *Handbook of the Psychology of Aging*. New York, Van Nostrand, 1976, p 357.

References generally should not exceed 30 in major articles, fewer in shorter articles.

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Illustrations include photographs, line drawings, graphs and charts. All illustrations should be numbered and cited within the text. X-ray films are generally not acceptable.

Electronic Artwork — Please note that *The JPOMA* cannot use line art or photographs that are inserted, embedded or copied into an electronic text file. Authors are asked to send the original electronic artwork files separately. Line art must be saved in .eps, .jpeg, .tif or .pdf format. Digital photographs should be sent using the highest print resolution available in .jpeg format, whenever possible. The minimum resolution for digital photographs in .jpeg format is 1024x768 pixels; no less than 72 dpi. Compressed .tif files with a minimum of 300 dpi are also acceptable. Scanned photographs should be sent at 100 percent of the original with a minimum resolution of 300 dpi.

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Other Illustrations — Figures, charts and graphs should be of professional quality. Lettering should be large and clear to allow for reduction, if necessary. Glossy, black-and-white prints of drawings, rather than originals, should be submitted whenever possible.

Editorial Review

Each article submitted will be forwarded to the editor-in-chief for review. Articles deemed acceptable will then be sent to the head of the POMA committee related to the subject involved, and an independent reviewer at the editor-in-chief's discretion. Authors whose articles are accepted for publication will be notified in writing, and will be notified if any rewrites or clarifications are needed before publication. Manuscripts submitted cannot be returned.

LECOM DEAN'S CORNER

Lake Erie College of Osteopathic Medicine

Silvia M. Ferretti, D.O.
LECOM Provost,
Vice President and
Dean of Academic Affairs

From nascence to national renown, from humble beginnings to hallmark of excellence — the Lake Erie College of Osteopathic Medicine (LECOM) demonstrates that all who have accomplished purposeful victories have held a high aim, have fixed their gaze upon a goal that was towering — one that sometimes seemed impossible — for this is the code of leadership.

Holding high the standard of this ever-fixed code stands LECOM, proudly positioned at the very center of an entirely new paradigm in health care.

LECOM is the core of the only *academic health center in the osteopathic profession*; an integral and inextricably linked part of *LECOM Health* — a highly innovative health care and education system that strives to add to the quality of life of its neighbors by bringing total health care to the community.

Offering a new model in health care delivery, LECOM is wholly unique among osteopathic medical schools. No other school of its kind can boast two hospitals, two skilled nursing facilities, a state-of-the-art fitness and wellness center, three independent senior living communities, along with home-health services (Visiting Nurses Association), an active aging-education and health-service agency (LifeWorks), and the clinical practices of Medical Associates of Erie (MAE).

As the tempestuous seas of an uncertain future of health care wash over the nation, as hospitals merge and clinical practices close, LECOM is building a thriving model medical education and health care delivery system.

This novel and sagacious stratagem is not unusual for LECOM. Recall that it was, as its very genesis two decades past, a wistful idea that crossed the minds of a few bold dreamers as they envisaged the future of osteopathic medicine.

"Fortune favors the bold," and in each age, men and women of vision undertake the ascent to pursue such a goal, to face the tempests of naysayers and cynics, remaining fixed upon their mission and purpose. To Virgil, "fortune" was comprised of purpose, freedom and the determination to realize one's full potential. Valued contributions to society demand such unflinching and persistent risks that create opportunities as well as leaders. LECOM is an organization replete with individuals who exercise leadership in support of its common purpose and in pursuit of the shared objectives of a noble calling. Just as LECOM came about as a bold response to community need, so too has its vision been set upon ever understanding that need.

This almost intuitive understanding allows LECOM to bolster the community-based education necessary to prepare medical, pharmacy and dental students. Cutting-edge health care facilities provide training for LECOM students under the guidance of medical educators, many of whom are graduates of the LECOM post-graduate residency programs and who have completed the LECOM Master's of Science in Medical Education degree.

Indeed, the model is visionary. It is the template from which others will take the cue; a model formed in the crucible of community commitment and professional exceptionalism.

What wakes LECOM leaders each morning? It is as much the credo as the calling; a common ground, fertile earth that remains to be tilled. It is the belief that the community's need is a vessel to fill; the knowledge that excellence is never an option, rather it is a standard. What is the foundation of a legacy? It is *LECOM Health*.

Fraternally,
Silvia M. Ferretti, D.O.

PCOM DEAN'S CORNER

Philadelphia College of Osteopathic Medicine

Kenneth J. Veit, D.O.
PCOM Provost, Senior Vice President for Academic Affairs and Dean

A recent study from the American Association of Medical Colleges found that only about 4 percent of practicing physicians identify as Hispanic/Latino, despite that group being the fastest growing segment of the U.S. population. The dearth of Hispanic physicians can mean an access to care issue, as research shows that minority patients are far more likely to receive care from physicians with a similar ethnic background.

The need for more diversity among health care practitioners is just another facet of this changing world of health care, and PCOM is working to meet this need head-on, by planting the seeds of success early in the lives of Hispanic students.

Recently, the college launched the PCOM Opportunities Academy, an intensive five-week pilot program designed to provide a pipeline that routes motivated students with an interest in science, technology, engineering, math and medicine (STEM+M) toward four-year degree programs and into training for the health professions. PCOM has partnered with two of Philadelphia's largest Hispanic-serving institutions, ASPIRA Schools of Pennsylvania and Esperanza, Inc., on the program.

Each week of the Academy focused on a different area of study, led by PCOM students, alumni and faculty. In addition, students in the Academy went on field trips to unique scientific institutions around the city, such as the Franklin Institute and the Mütter Museum; received SAT and ACT preparatory materials; and heard from health care leaders from various specialties and ethnic backgrounds.

While most of these types of pipeline programs stop after the summer ends, PCOM is working year-round with its partner institutions to continue the momentum that the Academy hopes to build among participating students. Throughout the year, PCOM faculty will collaborate with faculty from ASPIRA Schools and Esperanza on professional and curriculum development, and the establishment of practicum and research opportunities.

Students from ASPIRA Schools already benefit from our college's affiliations with national health prep programs, such as the Health Professions Recruitment Exposure Program and the Perry Initiative; and students from Esperanza College's Science and Medical Assisting programs are provided access to PCOM's laboratories and simulated clinical environments. ASPIRA Schools also serve as clinical practicum sites for PCOM's School of Psychology graduate programs.

We want to make sure these initiatives work. That's why we're working with our partner institutions to monitor the Academy's outcomes by tracking student performance in STEM+M skill building activities, as well as changes in students' career goals and confidence levels. A full evaluation of the Academy will also look at the influence this program has on our partner institutions' curricula and teaching methods.

Since its founding in 1899, PCOM has dedicated itself to the education of students in the health care fields, while at the same time staying committed to the well-being of the community through leadership and service. Through our partnerships with these two institutions, we are underscoring our dedication in these areas by addressing a pressing need in an innovative way.

Fraternally,
Kenneth J. Veit, D.O.

A STUDENT'S VOICE — LECOM

Jordan Spencer, OMS-II

Jordan Spencer
LECOM OMS-II

As the new school year began and new medical students arrived on their campus for the first time, they were excited to learn, anxious for what was ahead, and hopeful for the future. Many will be first generation physicians, while others will carry on legacies of medicine in their family history.

Second-year students returned with stories of summer adventures, research, training, vacations and classes. Goals will be set for future board scores and residency hopes (my own desktop background was recently embossed with St. Margaret Hospital). Third-year and fourth-year students are already moving forward to rotations and perspective residency decisions that will affect the rest of their careers and lives. All these years of education happen at a dizzying pace and all are unique to each individual.

No matter what stage of medical school training, each student has a shared sense of anxiety about what we have to look forward to in the field of medicine.

Medicine, in recent years, has undergone tremendous changes due to research advancements, legislative action and other factors. Few, if any, can say exactly what the landscape of medicine will look like when the first-year medical students of today become the physicians of tomorrow. As I visit with students and residents in all stages of medical training, a shared anxiety seems to be the only consistent element among everyone. This pervasive anxiety among students also comes with comfort; comfort in what has been laid ahead of us... by you. You, who are now the practicing physicians who will eventually turn the torch over to us, the rising generation.

As part of LECOM's three-year accelerated program (Primary Care Scholars Pathway), my summer is different from most others and is filled with classes. One of my summer courses was an innovative enrichment module in which we visited physicians and other inter-professional health care workers. These health professionals included physical and respiratory therapists, pharmacists, ultrasound technicians and other specialists within the field.

I can confidently and proudly say that each and every one of these professionals has a great respect for the osteopathic profession. They recognize a difference in how osteopathic physicians treat patients and the community as a whole. You, my predecessors, have created goodwill and understanding between the proverbial us and them. You have developed relationships that are to be commended, and developed a future for us to live into and up to. As a future osteopathic physician, I say thank you.

Thank you for standing apart from the crowd and making us a little bit different. We are different in our training and our philosophy, and it shows in our practice of medicine and how we treat others. I am proud to be a future D.O., and am thrilled with the osteopathic heritage from which I come. I have found pervasive opinions among patients and other professions that D.O.s are even-keel, thorough, kind, willing to listen, and intelligent. How can I not have a tinge of pride as I walk into a room with those attributes immediately assumed upon my person? Not because of anything I have yet done, but rather because of the group from which I come.

The future is bright for me and my fellow classmates. We are lucky to ride on the coattails of the profession you have developed until we ourselves can establish a rapport that hopefully compares to the one you have created. With a volatile political climate, constant battles with insurance companies, rising pressure on clinical output, and a patient population that is increasingly becoming older, there is plenty to bring one down. For me, these things are all realities that will, in their own time, need to be addressed. However, in the present, the courage I garner from the history that I carry gives me full confidence in my future and the future of my profession.

A STUDENT'S VOICE — PCOM

Elisa Giusto, OMS-III, and Olivia Hurwitz, OMS-III

As newly minted third-year students, we have spent the last couple months fumbling through various hospitals, trying to navigate talking to patients, performing procedures for the first time (without injuring anyone), and documenting our findings. The experience has been an even split between exhilarating and terrifying as we adjust not only to the medicine and pathology we see in the hospital, but also to the culture and social dynamics within the hospital system itself. Even the harder aspects of rotations — getting "pimped," constantly disappointing your attendings, and being in the way 90 percent of the time — have ended up being more like challenges to overcome than burdens to bear. One thing, however, has been notably surprising, disappointing, and does merit conscious discussion: the language used to talk about people with intellectual and developmental disabilities, both among health care professionals and on electronic medical records.

The term "mental retardation" and its derivatives are outdated, pejorative, and should be removed from the medical lexicon, both in speech and documentation. The term, while originally meant for unbiased clinical use, has become harmful to the very population it was created to protect — largely due to cultural bastardization — and it has, therefore, lost its clinical relevancy. The phrase "intellectual disability" is widely recognized as an alternative to its derisive precursor, and has been accepted for use in all federal legislature regarding health, education and labor in the United States since the signing of Rosa's Law in 2010. The intent behind the law was to foster "dignity, inclusion and respect of all people with intellectual disabilities," by removing hurtful language from official documents.[1] The movement has gained some traction in the medical field, and in 2011, the WHO ICD Working Group on the Classification of Intellectual Disabilities officially proposed integrating "intellectual disabilities" into ICD-11.[2] These efforts have long been supported by organizations like Special Olympics and Best Buddies International, which seek to integrate people with intellectual and developmental disabilities into the community through education, job placement and recreation.

People with intellectual and developmental disabilities have a centuries-long history of brutal discrimination and dehumanization, both in the United States and around the world, and have been faced with institutionalization, sterilization, segregation, abuse, neglect and even eugenics. It wasn't until the later part of the twentieth century that the government began to investigate and formally regulate the treatment of people with disabilities, resulting in several important pieces of protective legislation, such as the Individuals with Disabilities Education Act, the Fair Housing Act and, of course, the Americans with Disabilities Act of 1990.[3] Unfortunately, while these reforms have greatly increased the rights and quality of life for people with intellectual disabilities, stigma and discrimination are still rampant in the United States and can have dire effects on the health and well-being of Americans with disabilities.[4]

The marginalization of people with intellectual disabilities is a multifactorial issue that cannot be easily solved by changing a few words of our vocabulary, but more sensitive language choices by health care professionals can help ease the burden of discrimination against more vulnerable populations. If we, as a community, are more conscious of how we speak about people with disabilities, we will become more conscious of how we speak to people with disabilities and, likewise, how we treat them. There is no medical reason to use pejorative terms, including phrases like "slow" or "challenged," in discussions or electronic medical records, and it is very clear that harmful language only perpetuates the discrimination people with disabilities still face. While efficiency and consistency are essential to medical practice, we cannot hold them above respect for our patients.

(continued on page 38)

Elisa Giusto
PCOM OMS-III

Olivia Hurwitz
PCOM OMS-III

A YOUNG PHYSICIAN'S PERSPECTIVE

Mark B. Abraham, D.O., J.D.

Mark B. Abraham, D.O., J.D.

As I start typing, I have "Zika" in my head, but as though the late great Ray Charles was singing it to the tune of "Georgia on My Mind." How and why it got there, I don't know. I will let the psychiatrists reading this ponder that question over a bagel and coffee. That being said, what are we to do?

Data is starting to emerge that shows long-term brain damage, even in adults who have been exposed, is possible; that is potentially alarming. Modes of transmission — sexual and vector-borne. The American Red Cross now wants every blood donation screened for it. Not every batch (which typically is how other blood-borne pathogens have been screened), but every sample. While there are no known cases of transfusion-associated transmission, it is a logical concern.

I have encountered many patients in the urgent care setting who have been "potentially exposed" — anyone with a suspected insect bite who has traveled to a Zika location. Think about that. It is summer vacation. Families travel. People are bitten by mosquitoes, as well as other insects, and are often unsure as to what bit them. Given the nature of what I do, we do not order the testing here; it must occur through the PCP. There are many reasons for this, starting with not everyone with an insect bite was bitten by a mosquito that transmits Zika.

The fact that Zika is now in Florida is not shocking. It was a matter of time — just as with other vector illnesses such as West Nile Virus. It does, however, become problematic. The southern border is at risk as Zika starts to move through Central America. (I know, very easy segue into dealing with national security and immigration issues in an upcoming presidential election year — I will try and not digress.) Just think of what this could potentially mean for domestic vacations.

I heard a report the other day discussing the concern in Florida should Zika be discovered in Orlando. Orlando — home to Universal Studios, Sea World and, of course, Walt Disney World. How many people visit Orlando annually from all over the world? According to the website *www.VisitOrlando.com* — over 62 million people visited Orlando in 2014 — ***62 million***.

Think about the effect upon their economy should Zika present there. This would not just affect the parks, but all of the other neighboring attractions, such as restaurants and hotels. Lost revenue means possible loss of jobs, as well as a loss of tax dollars. Ultimately, tax dollars help fund research.

It is difficult to picture that one such condition would have such broad consequences. But, that is indeed the case. Think about the issues in advance of the Rio Olympic Games and the athletes who chose not to compete. If athletes were passing on their dream, how many fans and tourists also stayed away? Brazil may have profited from the games, but how much was lost?

Currently, it seems that the news cycle is inundated with either coverage of the election or Zika. I previously wrote about the issue of media dissemination of information, sometimes over-sensationalizing issues, sometimes providing good and valuable information. As issues with Zika emerge, more and more people want and need to know about exposure — such as young children, newborns/infants and pregnant women or families looking to conceive. However, another issue has started to arise that is due to the proper and responsible dispensing of information. I know of various circumstances involving ***pregnant women who have traveled to endemic areas with their husband/partner*** and are having a problem getting the lab test approved. Insurance companies are balking at the testing of husbands who are at risk of exposure and, thus, transmission.

This somewhat reminds me of the logic of insurance companies preferring to pay for treatment of COPD, heart disease and lung cancer, instead of for medication to help people quit.

At some point, things will level out. Hopefully, there will be an effective vaccine as well as more long-term studies showing the true risks and consequences of Zika. Until then, the dance continues. Will the elections have any effect upon this? Who knows?

Now, if we vet the mosquitoes, and fast track their entry into the United States, since we want to make sure that they can live the American dream given that is what America is all about, and so that they can all go to college for free, but after building a wall. . . . (Sorry, I couldn't resist.)

ABOUT THE AUTHORS

Matthew L. Hintz, D.O.

Patrick F. Fessler, D.O.

Matthew L. Hintz, D.O., received the third place award in the 2016 POMA Clinical Writing Contest for his manuscript, *"A Look at Aggressive Play and Intent to Injure Among Male Junior Hockey Players of the OHL."* Dr. Hintz is currently a third-year orthopedic surgery resident at Millcreek Community Hospital in Erie, Pennsylvania. He is a graduate of Johns Hopkins University in Baltimore, Maryland, and a 2014 graduate of the Lake Erie College of Osteopathic Medicine. Dr. Hintz is undertaking research relating to the anterior lateral ligament of the human knee and pursuing a Master's in Medical Education.

Patrick F. Fessler, D.O., received an honorable mention in this year's POMA Clinical Writing Contest for his article, *"Injury Underreporting in Collegiate and Professional Athletes."* A third-year orthopedic surgery resident at Millcreek Community Hospital in Erie, Pennsylvania, he is a graduate of the University of Notre Dame in South Bend, Indiana, and a 2014 graduate of the Philadelphia College of Osteopathic Medicine. Currently working on a Master's in Medical Education at the Lake Erie College of Osteopathic Medicine, Dr. Fessler has served with international humanitarian health organizations in Nicaragua and Hondorus.

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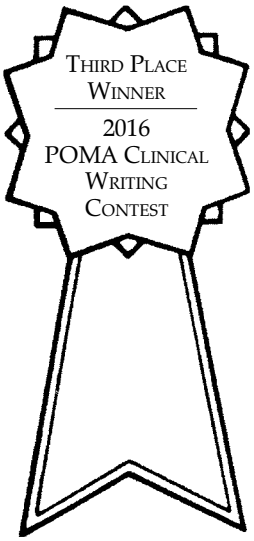
Medical Update
A Look at Aggressive Play and Intent to Injure Among Male Junior Hockey Players of the OHL

by Matthew L. Hintz, D.O.



Introduction

Ice hockey is a sport with a combination of high-speed competitive team play and physical contact that leads to numerous injuries every year. In a seven year review of injuries in men's and women's NCAA ice hockey games, male athletes experienced injuries at a rate of 18.69/1,000 athlete exposures and female athletes experienced injuries at a rate of 12.10/1,000 athlete exposures.[1] In another study looking specifically at the injury rates in Canadian minor league hockey, the overall injury rate was 30.02 injuries per 100 players per season, with higher rates at higher levels of play.[2]

When assessing the causation of ice hockey injuries one must not only include accidental occurrences resulting from the physical nature of the sport, but also account for aggressive play with rule violation and intent to injure. It can be difficult to focus a discussion on aggression with so many interpretations of the term in the English language. For this study, our working definition of aggression was taken from Baron, "Aggression is any form of behavior directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment."[3] Buss proposed a distinction between hostile aggression toward another who has provoked the aggressor, and instrumental aggression that serves as a means to a specific goal, where the opponent is injured impersonally, granting an advantage.[4,5]

In the realm of sports, the rules dictate which acts are allowed and which are not. Athletes rely on the referees and officials to enforce said code of conduct by issuing penalties. Studies have been performed to evaluate penalties in ice hockey as a measure of aggression. These provided mixed results for penalties other than fighting, and showed a correlation to aggression in multiple studies.[5] Widmeyer questioned NHL officials, players and semi-pro players about intentions behind committing acts for which penalties were assessed in order to address the fact that many aggressive acts in ice hockey are allowed within the rules of the game. Anecdotally, the responses garnered correlated acts of slashing, spearing, high-sticking, butt-ending, cross-checking, charging, boarding, kneeing, elbowing, roughing and fighting with intent to injure and intimidate.[6]

Much research has been done trying to evaluate the motivations of athletes performing aggressive acts in sporting events and intentional attempts to injure opponents. Repeatedly it has been shown that the factors of male gender, involvement in the sport in question, increased length of time involved in sport, and higher level of competition were associated with an increased athlete acceptance of aggressive rule-violating behavior as legitimate.[5,7-10] These results have been shown to roughly manifest as a continuum of acceptance based on severity of outcomes experienced by the target of aggressive acts.[7]

In a study looking at task and ego motivation (personal mastery vs. beating an opponent), it was found that a low-task and high-ego orientation was associated with higher incidence of unsportsmanlike play/cheating and perceived legitimacy of intentionally injurious behavior. Again, males also showed increased endorsement of unsportsmanlike play/cheating, strategic play, and intentionally injurious acts against opponents, though not permanently disabling acts.[11] Acceptance of aggressive and unsportsmanlike play has also been associated with athletes' acceptance of team behavioral norms and influence from coaching staff.[12,13]

The rates of penalties against teams has been shown to be dependent on multiple factors such as being the home team, whether the team has a small lead, whether the team is losing a close match or is highly outscored, and which period of the game it is. These findings point to a social learning context where athletes can test the informal structural norms of the contest presented by officials and evaluate the risk/benefit ratio of committing an aggressive act. The team with the superior position of the game will be more likely to commit a rule violation due to less perceived risk to the overall goal of winning.[14]

Research Question and Hypothesis

After a review of recent literature, the research group focused our efforts on addressing the question, "Are aggressive acts with intent to injure opponents a significant part of men's junior ice hockey due to strategy or hostile intent?" Our hypothesis prior to undertaking this study was that intentional injurious acts comprise a significant part of the game of men's junior ice hockey, and become justified as game strategy.

Materials and Methods

To explore the hypothesis, a descriptive epidemiological study was employed utilizing anonymous surveys of the athletes to gain information on the incidence of, and motivation behind, intent to injure at the male junior hockey level. Surveys were distributed to the teams within the Ontario Hockey League (OHL) through their respective athletic trainers to be filled out voluntarily by the athletes over 18 years old and returned via prepaid envelope. A review of the 2014-2015 rosters demonstrated a potential of 301 OHL athletes over the age of 18. The local Erie Otters junior hockey team was used as a point of contact, as our orthopedic and sports medicine groups work closely with them. The distributed survey is provided in Table A.

Results

After the surveys had been distributed, the participants returned 51 completed anonymously. The responses were gathered and organized. Numerical values of 1 through 5 were subsequently associated with the ordinal values of strongly disagree through strongly agree, respectively, to calculate a mean and mode for the responses to each survey question. This information is demonstrated in Table B. Bar graphs were created to provide a visual representation of the responses to each survey question demonstrated in Figures 1-10.

Discussion

It was found that the majority of respondents agreed that players are intentionally injured during OHL hockey games. Respondents also tended to agree that intimidation is an important part of competitive hockey, and that players justify aggressive play and injurious acts if they lead to success during competition. However, most participants responded that they felt they had not been targets of intentional injurious actions, and

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Players are intentionally injured during OHL ice hockey games.					
You have been the target of an intentionally injurious act during an OHL ice hockey game.					
Intimidation is an important part of competitive hockey.					
Players justify aggressive play and intentionally injurious acts if it leads to success during competition.					
Intentionally injurious acts can be justified as a part of game strategy.					
Intentionally injurious actions target players who are considered weak.					
Intentionally injurious actions target more influential players from opposing teams.					
Intentionally injurious actions target younger players.					
Intentionally injurious actions target players due to personal grudges.					
Intentional injuries would decrease if they resulted in automatic multiple game suspensions.					

that intentionally injurious acts should not be justified as a part of game strategy.

In terms of motivation, an overwhelming majority of respondents did not agree that intentionally injurious actions target younger or weaker players. However, the athletes show a tendency of agreement that intentionally injurious actions are often the result of personal grudges. This could be a result of the perceived emphasis on intimidation and aggressive play. Perhaps more concerning, the majority of respondents agreed that intentional injuries frequently target more influential opponents during competition. This is consistent with a dehumanization of opponents through a willingness to harm them for personal gain.

Finally, the majority responded in agreement that intentional injuries would decrease if they resulted in multiple game suspensions. This is just one potential intervention that may reduce the occurrence of intentional injuries at the level of the OHL. In order to move toward a reduction of non-accidental injuries among young athletes in the sport of hockey, we would benefit from further exploration into possible interventions and how to employ them. Future examination of when athletes begin to view intentional injuries as game strategy, and consideration of possible sources of this behavior, will be beneficial to begin developing potential action plans to protect young athletes.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Mean	Mode
Players are intentionally injured during OHL ice hockey games.	5	19	9	13	5	51	Neither Agree nor Disagree	Agree
	9.8%	37.3%	17.6%	25.5%	9.8%		3.12	4
You have been the target of an intentionally injurious act during an OHL ice hockey game.	3	12	10	19	7	51	Disagree	Disagree
	5.9%	23.5%	19.6%	37.3%	13.7%		2.71	2
Intimidation is an important part of competitive hockey.	13	21	12	4	0	50	Neither Agree nor Disagree	Agree
	26.0%	42.0%	24.0%	8.0%	0.0%		3.86	4
Players justify aggressive play and injurious acts if it leads to success during competition.	5	22	11	10	3	51	Neither Agree nor Disagree	Agree
	9.8%	43.1%	21.6%	19.6%	5.9%		3.31	4
Intentionally injurious acts can be justified as a part of game strategy.	1	7	16	18	8	50	Disagree	Disagree
	2.0%	14.0%	32.0%	36.0%	16.0%		2.50	2
Intentionally injurious actions target players who are considered weak.	0	3	19	21	8	51	Disagree	Disagree
	0.0%	5.9%	37.3%	41.2%	15.7%		2.33	2
Intentionally injurious actions target more influential players from opposing teams.	3	16	17	8	7	51	Neither Agree nor Disagree	Neither Agree nor Disagree
	5.9%	31.4%	33.3%	15.7%	13.7%		3.00	3
Intentionally injurious actions target younger players.	0	6	13	22	10	51	Disagree	Disagree
	0.0%	11.8%	25.5%	43.1%	19.6%		2.29	2
Intentionally injurious actions target players due to personal grudges.	4	16	19	10	2	51	Neither Agree nor Disagree	Neither Agree nor Disagree
	7.8%	31.4%	37.3%	19.6%	3.9%		3.20	3
Intentional injuries would decrease if they resulted in automatic multiple game suspensions.	6	13	14	10	8	51	Disagree	Neither Agree nor Disagree
	11.8%	25.5%	27.5%	19.6%	15.7%		2.98	3

Potential sources of bias within this study include personal bias of the researchers concerning the prevalence of and motivations behind intentional injuries at the level of the OHL when developing the questionnaire. Another potential source of bias with the young athletes is the perceived risk of coaches or trainers disciplining them due to their responses. Although steps were taken to maintain anonymity of the surveys, the athletes may have responded with perceived correct answers consistent with social desirability bias. Central tendency and acquiescence bias must also be considered when evaluating Likert type scales. A final source of bias includes a possible language barrier with the athletes, as many originate from other countries and English is potentially a second language for a subset of the participants.

Conclusion

Non-accidental injuries are a common occurrence in the sport of hockey. This survey has provided us with a better understanding of potential influences and motivations behind intentional injuries at the junior level within the OHL. From here, further studies can be undertaken, potentially employing methods such as action research, in an attempt to develop interventions to protect young athletes and transform the violent game strategies that have persisted within the sport. In

the future, it may prove beneficial to examine differences between offensive and defensive athletes' perceptions to better localize where on the ice intentional injuries have a predilection of occurring and who is most at risk. Another area of interest would be to examine for any correlation between aggressive play and intentions with particular developmental leagues to address violent play at an early stage in the athletes' careers. Overall, there is much more work to be done in developing a safer playing environment for our junior hockey athletes.

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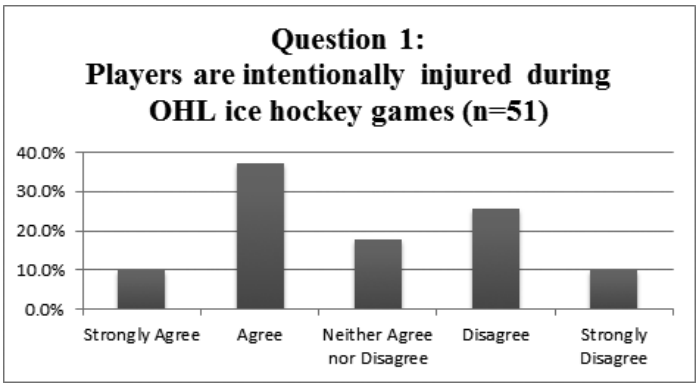

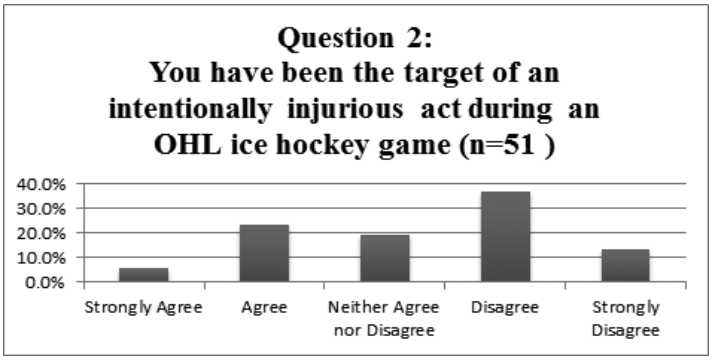

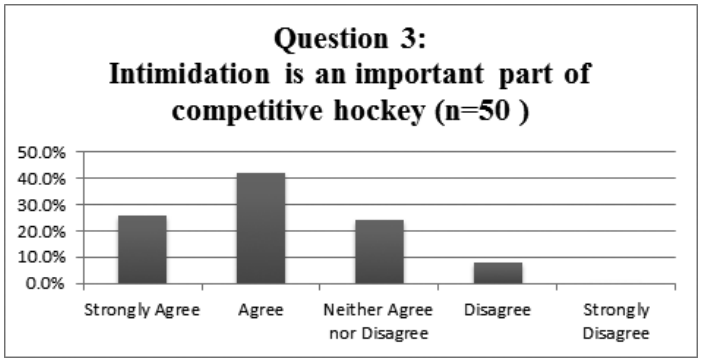

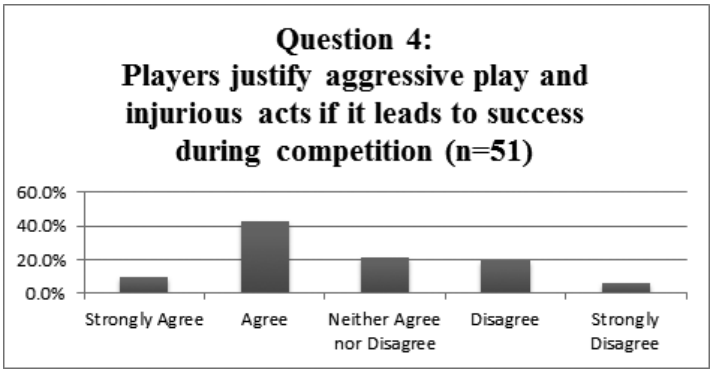

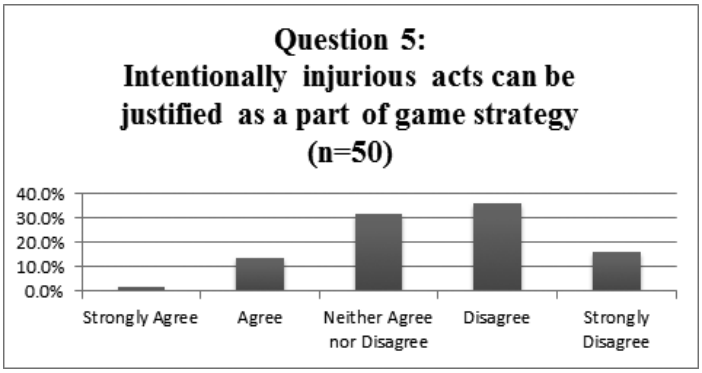

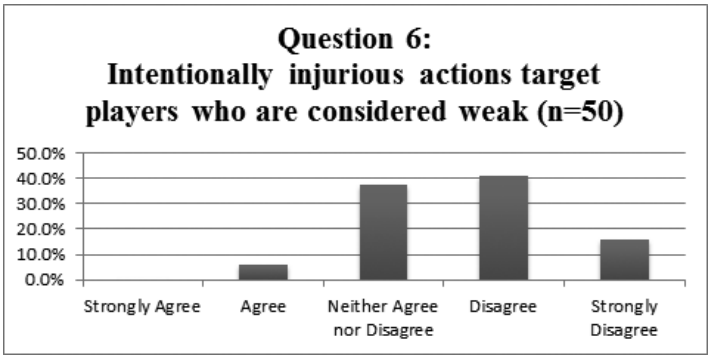

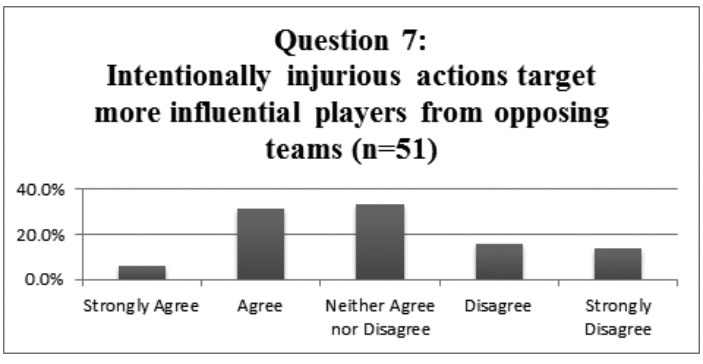

Dr. Hintz would like to thank Andrew Kupniewski, ATC, and Steven Habusta, D.O., M.Ed., for their contributions to this paper.

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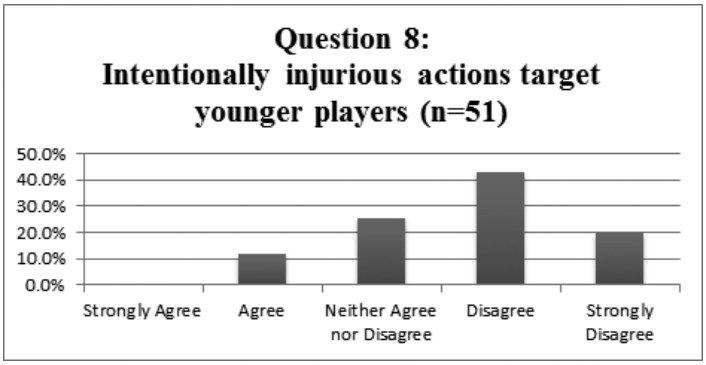
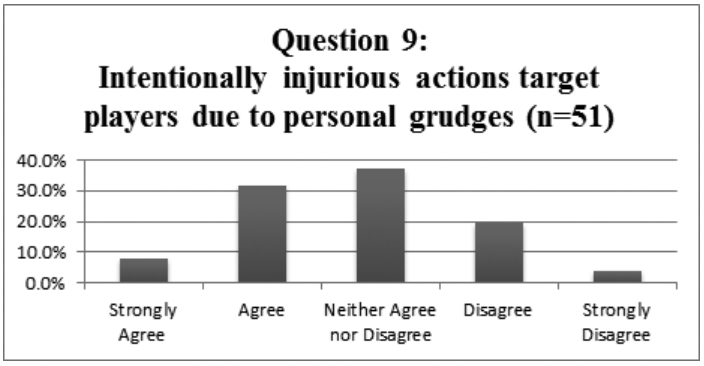
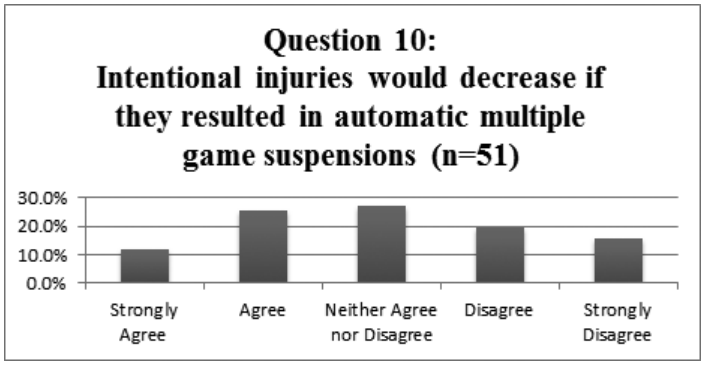
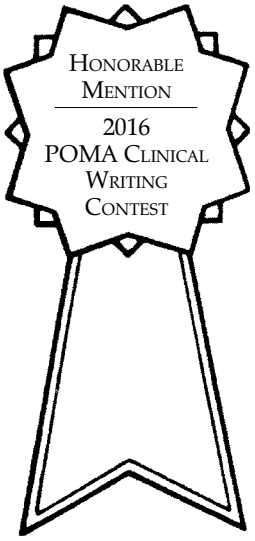






Medical Update
Injury Underreporting in College and Professional Athletes

by Patrick F. Fessler, D.O.



Question

Does the level of competition affect the likelihood for an athlete to underreport an injury?

Hypothesis

There will be a statistical difference in the number of injuries reported by athletes in different levels of competition. College athletes will be the most likely to withhold reporting injuries.

Materials and Methods

I will first propose to the Internal Review Board the opportunity to survey athletes without harming them, revealing their identity, or affecting their competition status. Pending IRB approval, I will design a survey and distribute them amongst the study participants for completion. The participants I hope to include, given the consent of the athletes and the IRB, are the Mercyhurst University football and basketball teams, the Erie Bayhawks and the Erie Explosion. With the completed surveys, I will compare and analyze the data, interpret the results, and draw conclusions.

Introduction

According to the National Federation of State High Schools Association, sports participation for the 2012-2013 school year reached an all-time high of 7,713,577 participants. This was an increase of 21,057 from the previous year, and this trend is projected to continue. Likewise, the NCAA cites 420,000 student athlete participants for the 2013-2014 academic years at over 1,200 institutions. As participant numbers increase, athletics at all levels become more competitive, athletes are becoming bigger, faster and stronger, and injury rates are on the rise.

At the high school level, most injuries occur during competition as compared to practice. Furthermore, the lower extremity was the most commonly injured area followed by upper extremity, head, face and neck. When injuries were sustained, more than half resulted in less than a week time loss.[1] Similarly, at the collegiate level, game injuries were more prevalent than practice injuries. The game injury rates were highest during the regular season, followed by postseason injuries, and then preseason injuries. Conversely, preseason practice had the highest rates of practice injuries recorded. When correlating injury rates with level of competition, injury rates increased as level of competition increased (i.e., injury rates increased from Division III to Division I). More than half of the injuries, in practices and games, were of the lower extremity, again followed by the upper extremity.[2]

All of this information is dependent on what is defined as an injury, and reliable reporting. An analysis of epidemiological sports studies by Brooks and Fuller proposed two widely accepted definitions. The first is any event that requires treatment by the team physician, whether it results in time loss or not. The second definition of injury used is an event that results in time loss from competition.[3] The documentation and method of recording the injury modify occurrence rates. In a study done by Bjerneboe, 14 Norwegian male football clubs were observed. A total of 174 injuries were recorded. During the study, physicians and athletic trainers recorded 141 injuries, and the players themselves reported 122 injuries. After analysis of the data, it was found that the physicians and athletic trainers had underestimated the injury rates by 24 percent.[4]

State education funds are stressed across the nation, causing schools to close and athletic programs to combine teams and funds. In addition, the NCAA is limited to the number of scholarships it can extend to student athletes taking their talents to the collegiate level. The need to remain in competition and maintain that level of competition is essential to evolve and progress to the next level as an athlete. This drive might compel athletes to hide injury events and not report them to medical person-

nel. This can leave the student athlete in a conflict of interest and vulnerable to further injury and future debilitation.

Data

See the following charts for data collected from professional and college football, and professional and college basketball players. A statistical analysis appears on page 21.

Discussion

Injuries are a significant aspect of every season in the realm of athletics. Organizations and league governing bodies employ rules and regulations to ensure the safety of the athletes on the fields of competition. This is currently evident throughout sports by the movement to minimize head injuries by the enactment of new rules to ensure appropriate contact and the modification of equipment to maximize the amount of protection of the athletes. Likewise, coaches, training staff and medical personnel work tirelessly to condition athletes for competition, manage injuries, and set protocol for return to play. This is standard in varying capacities at all levels of competition. However, all of these efforts are predicated on injury reporting by the athletes themselves and injury identification by staff.

Injury reporting in different levels of competition and sports of differing nature were compared and contrasted. When comparing and contrasting injury reporting and its perception at the collegiate and professional levels, no statistical differences were seen in the following aspects: injury reporting, injury reporting when individuals thought it would affect the final outcome of the game, injury reporting when they felt their position was in jeopardy, or injury reporting affected by peer perception. There were also no statistical differences in the opinions on the prevalence of injury underreporting or the prevalence of long-term injuries sustained as a result of injury underreporting.

However, when comparing the question of injury underreporting as a problem at their level of competition, college athletes viewed this as a more of a problem at their level of competition when compared to professional athletes. Comparing college football athletes and professional football athletes yielded the same results. The analysis of college and professional basketball proved differently. Professional basketball players reported that they were more likely to withhold reporting their injuries for fear of losing the game, and they played in more games that they felt they should not have participated in as a result of

Professional Football

Have you ever withheld telling your coach/trainer that you were injured?

Answer Options	Response Percent	Response Count
Yes	76.5%	13
No	23.5%	4
If yes, what kind of injury?		0
answered question		17
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

Answer Options	Response Percent	Response Count
Yes	41.2%	7
No	58.8%	10
answered question		17
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

Answer Options	Response Percent	Response Count
Yes	29.4%	5
No	70.6%	12
answered question		17
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

Answer Options	Response Percent	Response Count
Yes	5.9%	1
No	94.1%	16
answered question		17
skipped question		0

Have you ever been hurt and stayed in a game and looking back feel that you should not have participated?

Answer Options	Response Percent	Response Count
Yes	17.6%	3
No	82.4%	14
If Yes, what kind of injury?		0
answered question		17
skipped question		0

For any unreported injury you have sustained, have you noticed any negative long-term effects?

Answer Options	Response Percent	Response Count
Yes	13.3%	2
No	86.7%	15
If Yes, do you feel initial reporting would have altered your outcome?		0
answered question		17
skipped question		0

Do you think other athletes at your level of competition withhold reporting injuries?

Answer Options	Response Percent	Response Count
Yes	82.4%	14
No	17.6%	3
answered question		17
skipped question		0

Do you think under reporting injuries is a serious problem?

Answer Options	Response Percent	Response Count
Yes	5.9%	1
No	94.1%	16
answered question		17
skipped question		0

College Football

Have you ever withheld telling your coach/trainer that you were injured?

Answer Options	Response Percent	Response Count
Yes	52.5%	42
No	47.5%	38
If yes, what kind of injury?		38
answered question		80
skipped question		0

Number	Response Date	If yes, what kind of injury? Categories
1	Feb 25, 2015 3:01 AM	rolled ankles, concussions
2	Feb 25, 2015 1:26 AM	Ankle and wrist
3	Feb 25, 2015 1:24 AM	strain/sprain
4	Feb 25, 2015 1:12 AM	ribs
5	Feb 25, 2015 1:06 AM	Back, shoulder
6	Feb 25, 2015 12:52 AM	Can't recall
7	Feb 24, 2015 11:54 PM	Groin
8	Feb 24, 2015 10:26 PM	Hip pain
9	Feb 24, 2015 9:49 PM	all kinds
10	Feb 24, 2015 9:23 PM	Hip/ankle
11	Feb 24, 2015 8:21 PM	shoulder labrum and rotator cuff tear
12	Feb 24, 2015 8:11 PM	elbow
13	Feb 24, 2015 8:09 PM	Ankle injuries
14	Feb 24, 2015 8:03 PM	head,neck,hand
15	Feb 24, 2015 7:52 PM	Head
16	Feb 24, 2015 7:50 PM	Back
17	Feb 24, 2015 7:49 PM	Multiple
18	Feb 24, 2015 7:49 PM	Concussion
19	Feb 24, 2015 7:23 PM	Rolled ankle
20	Feb 24, 2015 6:44 PM	Labrum
21	Feb 24, 2015 3:15 PM	Shoulder
22	Feb 24, 2015 2:44 PM	shoulder, quad, ankle
23	Feb 24, 2015 2:19 PM	Hamstring pull
24	Feb 24, 2015 2:19 PM	Head injury and finger
25	Feb 24, 2015 2:17 PM	Concussion... Broken hand
26	Feb 24, 2015 2:17 PM	Minor. Ankle and knee injuries
27	Feb 24, 2015 2:12 PM	Concussion knee ankle back shoulder
28	Feb 24, 2015 1:12 PM	Shoulder injury
29	Feb 24, 2015 1:07 PM	Shoulder and back
30	Feb 24, 2015 12:38 PM	Ankle, knee , back
31	Feb 24, 2015 1:01 AM	Hip, back, ankle
32	Feb 24, 2015 12:35 AM	Concussion, contusions, cuts, soreness or pain in joints
33	Feb 23, 2015 11:43 PM	head, back, ankle, hand
34	Feb 23, 2015 10:49 PM	Concussion, knee
35	Feb 23, 2015 9:34 PM	Able to play through injury
36	Feb 23, 2015 7:36 PM	Head and ankle
37	Feb 23, 2015 7:27 PM	Concussion, minor shoulder pain
38	Feb 23, 2015 7:20 PM	TFCC tear wrist injury. Sprained Achilles tendon.

Have you ever been hurt and stayed in a game and looking back feel that you should not have participated?

Answer Options	Response Percent	Response Count
Yes	26.3%	21
No	73.8%	59
If Yes, what kind of injury?		14
answered question		80
skipped question		0

Number	Response Date	If Yes, what kind of injury? Categories
1	Feb 25, 2015 1:24 AM	sprain and strain
2	Feb 25, 2015 1:06 AM	Shoulder,
3	Feb 24, 2015 8:03 PM	Head
4	Feb 24, 2015 7:52 PM	Head
5	Feb 24, 2015 6:44 PM	Shoulder labrum
6	Feb 24, 2015 2:19 PM	Shoulder injury, head
7	Feb 24, 2015 2:17 PM	Concussion
8	Feb 24, 2015 12:38 PM	Back
9	Feb 24, 2015 12:35 AM	Concussion, dislocated shoulder
10	Feb 23, 2015 7:40 PM	sprain a
11	Feb 23, 2015 7:36 PM	Neck head
12	Feb 23, 2015 7:27 PM	Concussion
13	Feb 23, 2015 7:20 PM	TFCC tear wrist injury.
14	Feb 23, 2015 5:59 PM	Head

Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

Answer Options	Response Percent	Response Count
Yes	56.3%	45
No	43.8%	35
answered question		80
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

Answer Options	Response Percent	Response Count
Yes	50.0%	40
No	50.0%	40
answered question		80
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

Answer Options	Response Percent	Response Count
Yes	28.8%	23
No	71.3%	57
answered question		80
skipped question		0

For any unreported injury you have sustained, have you noticed any negative long-term effects?

Answer Options	Response Percent	Response Count
Yes	23.8%	19
No	76.3%	61
If Yes, do you feel initial reporting would have altered your outcome?		18
answered question		80
skipped question		0

Number	Response Date	If Yes, do you feel initial reporting would have altered your outcome? Categories
1	Feb 25, 2015 1:26 AM	Probably not
2	Feb 24, 2015 9:49 PM	yes
3	Feb 24, 2015 8:03 PM	Possibly
4	Feb 24, 2015 7:50 PM	Hard to say
5	Feb 24, 2015 6:44 PM	Yes
6	Feb 24, 2015 2:45 PM	Yes
7	Feb 24, 2015 2:19 PM	Repeated pulls
8	Feb 24, 2015 2:17 PM	Maybe... I get unexplained headaches
9	Feb 24, 2015 2:12 PM	Yes
10	Feb 24, 2015 1:01 AM	Yes
11	Feb 24, 2015 12:35 AM	Yes, I would have had shoulder surgery 4 years ago instead of now
12	Feb 23, 2015 11:43 PM	my back would be in better shape than it is now
13	Feb 23, 2015 10:49 PM	Yes
14	Feb 23, 2015 9:34 PM	No
15	Feb 23, 2015 7:36 PM	Yes
16	Feb 23, 2015 7:27 PM	Memory, Ankle pain, shoulder pain
17	Feb 23, 2015 7:20 PM	No
18	Feb 23, 2015 7:12 PM	Most likely

Do you think other athletes at your level of competition withhold reporting injuries?

Answer Options	Response Percent	Response Count
Yes	90.0%	72
No	10.0%	8
answered question		80
skipped question		0

Do you think under reporting injuries is a serious problem?

Answer Options	Response Percent	Response Count
Yes	71.3%	57
No	28.8%	23
answered question		80
skipped question		0

College Basketball

Have you ever withheld telling your coach/trainer that you were injured?

Answer Options	Response Percent	Response Count
Yes	33.3%	4
No	66.7%	8
If yes, what kind of injury?		3
answered question		12
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

Answer Options	Response Percent	Response Count
Yes	33.3%	4
No	66.7%	8
answered question		12
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

Answer Options	Response Percent	Response Count
Yes	25.0%	3
No	75.0%	9
answered question		12
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

Answer Options	Response Percent	Response Count
Yes	8.3%	1
No	91.7%	11
answered question		12
skipped question		0

Have you ever been hurt and stayed in a game and looking back feel that you should not have participated?

Answer Options	Response Percent	Response Count
Yes	8.3%	1
No	91.7%	11
If Yes, what kind of injury?		1
answered question		12
skipped question		0

For any unreported injury you have sustained, have you noticed any negative long-term effects?

Answer Options	Response Percent	Response Count
Yes	25.0%	3
No	75.0%	9
If Yes, do you feel initial reporting would have altered your outcome?		2
answered question		12
skipped question		0

Do you think other athletes at your level of competition withhold reporting injuries?

Answer Options	Response Percent	Response Count
Yes	75.0%	9
No	25.0%	3
answered question		12
skipped question		0

Do you think under reporting injuries is a serious problem?

Answer Options	Response Percent	Response Count
Yes	25.0%	3
No	75.0%	9
answered question		12
skipped question		0

Professional Basketball

Have you ever withheld telling your coach/trainer that you were injured?

Answer Options	Response Percent	Response Count
Yes	42.9%	3
No	57.1%	4
If yes, what kind of injury?		2
answered question		7
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

Answer Options	Response Percent	Response Count
Yes	14.3%	1
No	85.7%	6
answered question		7
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

Answer Options	Response Percent	Response Count
Yes	85.7%	6
No	14.3%	1
answered question		7
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

Answer Options	Response Percent	Response Count
Yes	14.3%	1
No	85.7%	6
answered question		7
skipped question		0

Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

Answer Options	Response Percent	Response Count
Yes	14.3%	1
No	85.7%	6
answered question		7
skipped question		0

For any unreported injury you have sustained, have you noticed any negative long-term effects?

Answer Options	Response Percent	Response Count
Yes	28.6%	2
No	71.4%	5
If Yes, do you feel initial reporting would have altered your outcome?		1
answered question		7
skipped question		0

Do you think other athletes at your level of competition withhold reporting injuries?

Answer Options	Response Percent	Response Count
Yes	85.7%	6
No	14.3%	1
answered question		7
skipped question		0

Do you think under reporting injuries is a serious problem?

Answer Options	Response Percent	Response Count
Yes	28.6%	2
No	71.4%	5
answered question		7
skipped question		0

Basketball

3 Have you ever withheld telling your coach/trainer that you were injured?

	Yes		No		Marginal Row Totals
College	4 (4.42)	[0.04]	8 (7.58)	[0.02]	12
Professional	3 (2.58)	[0.07]	4 (4.42)	[0.04]	7
Marginal Column Totals	7		12	19	(Grand Total)

The Chi-square statistic is 0.1723. The P value is 0.678044. This result is not significant at p < 0.05.

4 Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

	Yes		No		Marginal Row Totals
College	4 (3.16)	[0.22]	8 (8.84)	[0.08]	12
Professional	1 (1.84)	[0.38]	6 (5.16)	[0.14]	7
Marginal Column Totals	5		14	19	(Grand Total)

The Chi-square statistic is 0.8272. The P value is 0.36308. This result is not significant at p < 0.05.

5 Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

	Yes		No		Marginal Row Totals
College	3 (5.68)	[1.27]	9 (6.32)	[1.14]	12
Professional	6 (3.32)	[2.17]	1 (3.68)	[1.96]	7
Marginal Column Totals	9		10	19	(Grand Total)

The Chi-square statistic is 6.5369. The P value is 0.010566. This result is significant at p < 0.05.

6 Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

	Yes		No		Marginal Row Totals
College	1 (1.26)	[0.05]	11 (10.74)	[0.01]	12
Professional	1 (0.74)	[0.09]	6 (6.26)	[0.01]	7
Marginal Column Totals	2		17	19	(Grand Total)

The Chi-square statistic is 0.1663. The P value is 0.683406. This result is not significant at p < 0.05.

7 Have you ever stayed in a game and looking back feel that you should nt have participated?

	Yes		No		Marginal Row Totals
College	1 (3.79)	[2.05]	11 (8.21)	[0.95]	12
Professional	5 (2.21)	[3.52]	2 (4.79)	[1.62]	7
Marginal Column Totals	6		13	19	(Grand Total)

The Chi-square statistic is 8.1458. The P value is 0.004316. This result is significant at p < 0.05.

8 For any unreported injury you have sustained, have you noticed any negative long-term effects?

	Yes		No		Marginal Row Totals
College	3 (3.16)	[0.01]	9 (8.84)	[0]	12
Professional	2 (1.84)	[0.01]	5 (5.16)	[0]	7
Marginal Column Totals	5		14	19	(Grand Total)

The Chi-square statistic is 0.0291. The P value is 0.864591. This result is not significant at p < 0.05.

9 Do you think other athletes at your level of competition withold reporting injuries?

	Yes		No		Marginal Row Totals
College	9 (9.47)	[0.02]	3 (2.53)	[0.09]	12
Professional	6 (5.53)	[0.04]	1 (1.47)	[0.15]	7
Marginal Column Totals	15		4	19	(Grand Total)

The Chi-square statistic is 0.3054. The P value is 0.580543. This result is not significant at p < 0.05.

10 Do you think under reporting injuries is a serious problem?

	Yes		No		Marginal Row Totals
College	3 (5.68)	[1.27]	9 (6.32)	[1.14]	12
Professional	6 (3.32)	[2.17]	1 (3.68)	[1.96]	7
Marginal Column Totals	9		10	19	(Grand Total)

The Chi-square statistic is 6.5369. The P value is 0.010566. This result is significant at p < 0.05.

their injuries. Also, professional basketball players felt that injury reporting was more of a problem at their level compared to college basketball.

Collegiate athletics limits its athletes to four years of active competition. Sustaining injuries, no matter how minor, can use up precious eligibility. The collegiate institution studied participates in Division II competition. Most of these athletes will not pursue a professional sports career. This further emphasizes that these athletes will want to maximize their availability to play and compete despite injury. Another theory is that collegiate athletes do not receive any form of compensation for their status on the team. Therefore, playing time is the only real source of value at this level.

Professional athletes oftentimes have contracts and receive compensation despite the number of minutes played or having to sit a game or two out to manage an

Football

3 Have you ever withheld telling your coach/trainer that you were injured?

	Yes		No		Marginal Row Totals
College	42 (45.36)	[0.25]	38 (34.64)	[0.33]	80
Professional	13 (9.64)	[1.17]	4 (7.36)	[1.53]	17
Marginal Column Totals	55		42	97	(Grand Total)

The Chi-square statistic is 3.2814. The P value is 0.07007. This result is not significant at p < 0.05.

4 Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

	Yes		No		Marginal Row Totals
College	45 (42.89)	[0.1]	35 (37.11)	[0.12]	80
Professional	7 (9.11)	[0.49]	10 (7.89)	[0.57]	17
Marginal Column Totals	52		45	97	(Grand Total)

The Chi-square statistic is 1.2809. The P value is 0.257727. This result is not significant at p < 0.05.

5 Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

	Yes		No		Marginal Row Totals
College	40 (37.11)	[0.22]	40 (42.89)	[0.19]	80
Professional	5 (7.89)	[1.06]	12 (9.11)	[0.91]	17
Marginal Column Totals	45		52	97	(Grand Total)

The Chi-square statistic is 2.3896. The P value is 0.122142. This result is not significant at p < 0.05.

6 Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

	Yes		No		Marginal Row Totals
College	23 (19.79)	[0.52]	57 (60.21)	[0.17]	80
Professional	1 (4.21)	[2.44]	16 (12.79)	[0.8]	17
Marginal Column Totals	24		73	97	(Grand Total)

The Chi-square statistic is 3.9375. The P value is 0.047221. This result is significant at p < 0.05.

7 Have you ever stayed in a game and looking back feel that you should nt have participated?

	Yes		No		Marginal Row Totals
College	21 (19.79)	[0.07]	59 (60.21)	[0.02]	80
Professional	3 (4.21)	[0.35]	14 (12.79)	[0.11]	17
Marginal Column Totals	24		73	97	(Grand Total)

The Chi-square statistic is 0.5573. The P value is 0.45536. This result is not significant at p < 0.05.

8 For any unreported injury you have sustained, have you noticed any negative long-term effects?

	Yes		No		Marginal Row Totals
College	19 (17.32)	[0.16]	61 (62.68)	[0.05]	80
Professional	2 (3.68)	[0.77]	15 (13.32)	[0.21]	17
Marginal Column Totals	21		76	97	(Grand Total)

The Chi-square statistic is 1.1873. The P value is 0.275867. This result is not significant at p < 0.05.

9 Do you think other athletes at your level of competition withold reporting injuries?

	Yes		No		Marginal Row Totals
College	72 (70.93)	[0.02]	8 (9.07)	[0.13]	80
Professional	14 (15.07)	[0.08]	3 (1.93)	[0.6]	17
Marginal Column Totals	86		11	97	(Grand Total)

The Chi-square statistic is 0.8155. The P value is 0.366508. This result is not significant at p < 0.05.

10 Do you think under reporting injuries is a serious problem?

	Yes		No		Marginal Row Totals
College	57 (47.84)	[1.76]	23 (32.16)	[2.61]	80
Professional	1 (10.16)	[8.26]	16 (6.84)	[12.29]	17
Marginal Column Totals	58		39	97	(Grand Total)

The Chi-square statistic is 24.9198. The P value is 1E-06. This result is significant at p < 0.05.

College vs. Professional

3 Have you ever withheld telling your coach/trainer that you were injured?

	Yes		No		Marginal Row Totals
College	46 (49.28)	[0.22]	47 (43.72)	[0.25]	93
Professional	16 (12.72)	[0.85]	8 (11.28)	[0.95]	24
Marginal Column Totals	62		55	117	(Grand Total)

The Chi-square statistic is 2.2667. The P value is 0.132179. This result is not significant at p < 0.05.

4 Have you ever withheld telling your coach/trainer you were hurt for fear of losing your position?

	Yes		No		Marginal Row Totals
College	49 (45.31)	[0.3]	44 (47.69)	[0.29]	93
Professional	8 (11.69)	[1.17]	16 (12.31)	[1.11]	24
Marginal Column Totals	57		60	117	(Grand Total)

The Chi-square statistic is 2.8604. The P value is 0.090783. This result is not significant at p < 0.05.

5 Have you ever withheld telling your coach/trainer you were hurt for fear of losing the game?

	Yes		No		Marginal Row Totals
College	44 (43.72)	[0]	49 (49.28)	[0]	93
Professional	11 (11.28)	[0.01]	13 (12.72)	[0.01]	24
Marginal Column Totals	55		62	117	(Grand Total)

The Chi-square statistic is 0.0167. The P value is 0.897053. This result is not significant at p < 0.05.

6 Have you ever withheld telling your coach/trainer you were hurt because you feared the perception by your peers?

	Yes		No		Marginal Row Totals
College	24 (20.67)	[0.54]	69 (72.33)	[0.15]	93
Professional	2 (5.33)	[2.08]	22 (18.67)	[0.6]	24
Marginal Column Totals	26		91	117	(Grand Total)

The Chi-square statistic is 3.3698. The P value is 0.066401. This result is not significant at p < 0.05.

7 Have you ever stayed in a game and looking back feel that you should nt have participated?

	Yes		No		Marginal Row Totals
College	23 (24.64)	[0.11]	70 (68.36)	[0.04]	93
Professional	8 (6.36)	[0.42]	16 (17.64)	[0.15]	24
Marginal Column Totals	31		86	117	(Grand Total)

The Chi-square statistic is 0.7248. The P value is 0.394565. This result is not significant at p < 0.05.

8 For any unreported injury you have sustained, have you noticed any negative long-term effects?

	Yes		No		Marginal Row Totals
College	22 (20.67)	[0.09]	71 (72.33)	[0.02]	93
Professional	4 (5.33)	[0.33]	20 (18.67)	[0.1]	24
Marginal Column Totals	26		91	117	(Grand Total)

The Chi-square statistic is 0.5392. The P value is 0.462777. This result is not significant at p < 0.05.

9 Do you think other athletes at your level of competition withold reporting injuries?

	Yes		No		Marginal Row Totals
College	82 (81.08)	[0.01]	11 (11.92)	[0.07]	93
Professional	20 (20.92)	[0.04]	4 (3.08)	[0.28]	24
Marginal Column Totals	102		15	117	(Grand Total)

The Chi-square statistic is 0.3996. The P value is 0.527285. This result is not significant at p < 0.05.

10 Do you think under reporting injuries is a serious problem?

	Yes		No		Marginal Row Totals
College	32 (27.82)	[0.63]	61 (65.18)	[0.27]	93
Professional	3 (7.18)	[2.43]	21 (16.82)	[1.04]	24
Marginal Column Totals	35		82	117	(Grand Total)

The Chi-square statistic is 4.3674. The P value is 0.036632. This result is significant at p < 0.05.

injury. In addition, professional athletes aim to prolong their careers and maintain health in order to do so. Not reporting an injury would lead to a lack of appropriate treatment and management allowing the injury to continue or possibly progress, jeopardizing their career. Analyzing injury reporting from a pure basketball perspective was contradictory to my hypothesis. I felt that college athletes were more likely to play with injuries, despite their lasting effects, for the sole compensation of winning.

Several aspects of how my research was conducted may have confounded my data. My collegiate data was largely represented by the football team, causing the data to be more representative of the football team when comparing to collegiate and professional sports as a whole. Another aspect of my research that may not have validated my data is that the football team surveyed was an indoor football team consisting of different rules and regulations than their college counterparts.

Conclusion

When comparing injury reporting at the collegiate and professional levels, there statistically was no difference overall. Injury underreporting was seen as a problem by college athletes overall when compared to professional athletes. However, when examining the topic from a basketball perspective, professional basketball players thought injury underreporting was more of a problem at their level, and they were more likely to hide injuries in order to win games.

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Dr. DiMarco Leads Pennsylvania Delegation to Annual AOA House Meeting

POMA President Anthony E. DiMarco, D.O., led Pennsylvania's delegation to the American Osteopathic Association's (AOA) House of Delegates meeting, which was held July 22-24, 2016, in Chicago, Illinois. Forty-six physician delegates and two student delegates — one each from the Lake Erie College of Osteopathic Medicine and the Philadelphia College of Osteopathic Medicine — traveled to the meeting. The POMA delegation also included 14 physician alternates and one student alternate from each school.

POMA past president Ernest R. Gelb, D.O., was re-elected to a three-year term as a member of the AOA board of trustees during the meeting (see related story on page 25 of this issue of *The JPOMA*), and POMA Trustee Kenneth J. Veit, D.O., was awarded an AOA Presidential Citation during an awards luncheon held in conjunction with the House of Delegates meeting (see related article on page 24 of this issue of *The JPOMA*).

The AOA also presented Strategic Team Awards and Recognition, known as STARs, to the American College of Osteopathic Emergency Physicians (ACOEP), including two POMA members, John C. Prestosh, D.O., ACOEP president, and Christine F. Giesa, D.O., ACOEP president-elect.

Dr. DiMarco chaired the Reference Committee on Public Affairs, which reviewed 41 resolutions; while George D. Vermeire, D.O., served as vice chair, and Robert S. Jones, D.O., served as a member of the Reference Committee on Professional Affairs, which reviewed 53 resolutions. Joan M. Grzybowski, D.O., served as a member of the Reference Committee on Educational Affairs, which reviewed 20 resolutions; and Katherine E. Galluzzi, D.O., and Lisa A. Witherite-Rieg, D.O., served as members of the Ad Hoc Reference Committee, which reviewed 48 resolutions. William A. Wewer, D.O., served as a member of the Joint Board/House Budget Review Committee, which reviewed two resolutions; and Pamela S.N. Goldman, D.O., served as member of the Reference Committee on Constitution and Bylaws, which reviewed 12 resolutions. Joseph M.P. Zawisza, D.O., served as a member of the Credentials Committee; while Jeffery J. Dunkelberger, D.O., served as a member of the Committee on Rules and Order of Business.

POMA would like to thank all of the physicians who participated for a job well done!

POMA Trustee Kenneth J. Veit, D.O., Receives AOA Presidential Citation

On Saturday, July 23, 2016, POMA Trustee Kenneth J. Veit, D.O., was among four D.O.s to receive a presidential citation from American Osteopathic Association (AOA) President John W. Becher, D.O. The citations were presented at an awards luncheon that was held during the annual AOA House of Delegates meeting in Chicago, Illinois. Dr. Veit was honored for his dedication to patient care and his commitment to training the next generation of osteopathic physicians.

Serving the osteopathic profession for 40 years, Dr. Veit is provost, senior vice president for academic affairs, and dean of the Philadelphia College of Osteopathic Medicine (PCOM). As PCOM's dean since 1992, he has overseen the education and development of more than 20 classes of young D.O.s. He has also been instrumental in expanding the college's program beyond the boundaries of the Commonwealth, with a thriving campus in Georgia.

A POMA Distinguished Service Award recipient in 2015, Dr. Veit is board certified in family medicine. He is a graduate of Muhlenberg University in Allentown, Pennsylvania, and a 1976 graduate of PCOM. Dr. Veit completed an internship at the United States Public Health Service Hospital in Staten Island, New York; an occupational and environmental medicine residency at Rutgers Medical School in Newark, New Jersey; and a primary care health policy fellowship at the United States Public Health Service in Washington, D.C.

A fellow of the American College of Osteopathic Family Physicians and the College of Physicians of Philadelphia, Dr. Veit is a member of the POMA board of trustees and educational program chairman for the POMA Annual Clinical Assembly. He is also a member of the Pennsylvania Osteopathic Family Physicians Society, the American Osteopathic Association, the American Academy of Physician Executives and the Association of Osteopathic Directors and Medical Educators.

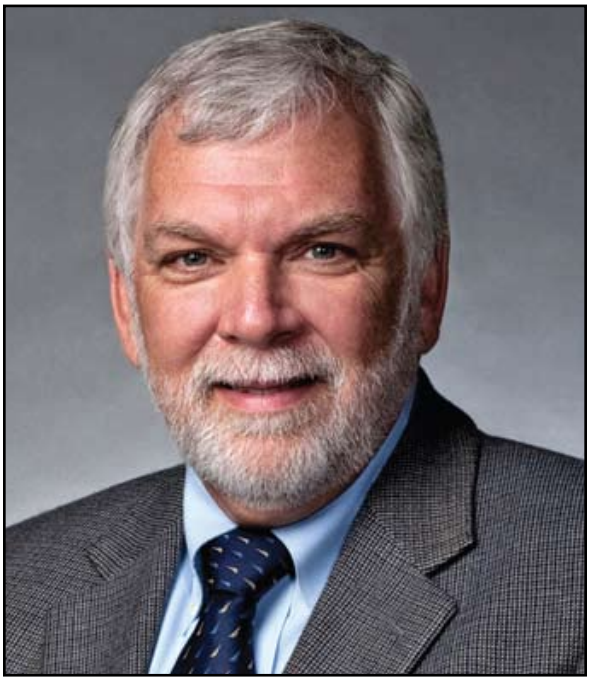
Ernest R. Gelb, D.O., Re-elected to AOA Board of Trustees

POMA past president Ernest R. Gelb, D.O., was re-elected to a three-year term as a member of the American Osteopathic Association's (AOA) board of trustees during the AOA's annual House of Delegates meeting, which was held July 22-24, 2016, in Chicago, Illinois.

Board certified in family practice/osteopathic manipulative medicine with a certificate of added qualification in geriatrics, Dr. Gelb is medical director of the Sullivan County Medical Center in Laporte, Pennsylvania, and an assistant professor of family medicine at the Philadelphia College of Osteopathic Medicine (PCOM).

Secretary/treasurer of the Pennsylvania Osteopathic Family Physicians Society and a board member of the POMA Foundation, Dr. Gelb is chairman of the POMA Bureau of Convention and Professional Meetings and a member of the finance, awards and family practice committees.

A fellow of the American College of Osteopathic Family Physicians, Dr. Gelb is a graduate of King's College in Wilkes-Barre, Pennsylvania, and a 1978 graduate of PCOM. He completed his postgraduate training at Botsford General Hospital in Farmington Hills, Michigan.



Pay 2016-2017 POMA Membership Dues Online

POMA dues invoices for the 2016-2017 membership year have been mailed to physician offices.

Invoices can be remitted with check or credit card payment to the POMA Central Office, 1330 Eisenhower Boulevard, Suite 100, Harrisburg, PA 17111-2319. Credit card payments may also be made by calling the Central Office at (717) 939-9318, or by logging into the POMA website, *www.poma.org*. *Please note, you must be a registered user of the POMA website to access this feature.*

Instructions to Pay POMA Membership Dues Online

- Visit *www.poma.org*.
- Click *Login* on the upper right hand side of the page.
- Enter your AOA number (without the leading zero) and password. Click *Login*.
- Click *Pay Dues* in the POMA membership box on the left side of the home page.
- Complete the membership dues invoice and click *Pay*.
  You will be directed to the PayPal website to process your payment information.

Forgot Your Password for the POMA Website?

- Click *Login* on the upper right hand side of the page.
- Click *Forgot Password*.
- Enter your AOA number (without the leading zero) and click *Send Password*. The password will be sent to the e-mail address you provided when signing up as a user of the POMA website.

Need Additional Help?

Don't remember if you are a registered user of the POMA website? Are you not receiving the password request e-mail? Feel free to call the POMA Central Office at (717) 939-9318, ext. 15 or e-mail *prc@poma.org*.

Our Future Leaders of

This spring, our nation's osteopathic medical colleges welcomed approximately 5,500 new D.O.s into the profession. As the osteopathic leaders of tomorrow begin their medical careers, POMA would like to take this opportunity to welcome them into the D.O. family.

In Pennsylvania, the Lake Erie College of Osteopathic Medicine held its 20th commencement ceremony on May 29, 2016, at the Erie Insurance Arena in Erie. The college conferred degrees upon 353 new D.O.s from the Erie and Seton Hill campuses. On June 5, 2016, the Philadelphia College of Osteopathic Medicine held its 125th commencement ceremonies for 260 new D.O.s at The Kimmel Center for the Performing Arts in Philadelphia.

Congratulations to all of 2016's D.O. graduates — may you enjoy long and rewarding careers in osteopathic medicine.

Lake Erie College of Osteopathic Medicine

POMA Outstanding Student Award
Presented to Nathan Angrett, D.O., and Sara Loucks, D.O., by POMA Executive Director Mario E.J. Lanni, D.Sc. (center).

Coppola Memorial Award
Presented to Bethany Calabrese, D.O., by Mary L. Eckert (right), president/CEO of Millcreek Community Hospital.

Czarnecki and Coppola Awarda
Richard A. Ortoski, D.O. (center), regional dean and chair, Department of Primary Care Education, presented Benjamin Segerson, D.O. (left), with the Czarnecki Award, and Joseph Cioccio, D.O., was awarded the Coppola Award.

The Dean's Award
Presented to Daniel Guck, D.O., and Kieren Kaveney-Lupo, D.O. (right), by Silvia M. Ferretti, D.O., vice president, provost and dean of academic affairs.

Dedication to Primary Care Award in Internal Medicine
Presented to Aaron Levit, D.O. (left), and Sanket Patel, D.O., by Dr. Ortoski.

Dedication to Primary Care Award in OB/GYN
Presented to Stephanie Santoro, D.O., by Dr. Ortoski.

Dedication to Primary Care Award in Pediatrics
Presented to Mahad Mohammed, D.O. (left), and Brooke Blazius, D.O., by Dr. Ortoski.

Eckert Memorial Award
Presented to Michael Dobrowolski, D.O., by Ms. Eckert.

Esper Award
Presented to Joseph Lapinksy, D.O., by Erik O. Esper, D.O. (right).

Osteopathic Medicine

Excellence in Surgery Award
Presented to Delandy McConnell, D.O., by Regan Shabloski, D.O., assistant dean of clinical education.

Fierro Award for Excellence in Internal Medicine
Presented to Christian Mosebach, D.O., by Dr. S. Ferretti.

Fucci Memorial Award
Presented to Catherine Patrick, D.O., by Ms. Eckert.

Garloff Excellence in Psychiatry Award
Presented to Tatum Kutzer, D.O., and Sean Bennett, D.O. (right), by Dr. Lanni.

Hampton OMM Award
Presented to Christopher Bowen, D.O., and Adam Link, D.O., by Jan Hendryx, D.O. (right), LECOM director of osteopathic principles and practice, and Kevin Thomas, D.O. (left), Seton Hill OMM faculty member.

Hirtzel Memorial Foundation Merit and Scholarship Award
Presented to (left to right) Jason Daughety, D.O., Benjamin Davis, D.O., and Benjamin Gough, D.O., by Dr. S. Ferretti.

Kelley Award for Family Medicine
Presented to Catherine Conway, D.O., by Dr. S. Ferretti.

Latorella and Mazzio Memorial Award
Presented to Zachary Novakovic, D.O., by Joan Moore, D.O., LECOM trustee.

Manco and Moore Memorial Award
Presented to James Nemunaitis, D.O., by Ms. Eckert.

Joseph J. Namey Family Medicine Award
Presented to Theresa Yurkonis, D.O., and Allen Shepard, D.O., by Dr. Ortoski.

Michael J. Namey, Jr., D.O., Award
Presented to Taylor Johnson, D.O., by Ms. Eckert.

Schaffner Award
Presented to Amanda Wincik, D.O., by Ms. Eckert.

Philadelphia College of Osteopathic Medicine

POMA Outstanding Student Award
Presented to Lee Paulson, D.O., by Anthony E. DiMarco, D.O., POMA president.

Alumni Association Award
Presented to William Ensor, D.O. (right), by William F. Swallow, D.O. (left), member of the PCOM Alumni Association Board of Directors.

Ruth Waddel Cathie, D.O., Memorial Award
Presented to Emily Kemner-Kozlowski, D.O., and Justin Ross, D.O., by Lindon Young, Ph.D. (center), professor, Department of Microbiology and Immunology.

Daiber Award
Presented to Benjamin Horn, D.O., by Bruce Kornberg, D.O. (left), chairman, Division of Cardiology.

Dean's Award
Presented to Ben Whitfield, D.O., by Kenneth J. Veit, D.O. (left), provost, senior vice president for academic affairs and dean.

DeMasi and Belsky Award
Presented to Laurel Garber, D.O., by Mark A. DeMasi, D.O.

Dickerson Memorial Award
Presented to Kyle Sherrod, D.O., by Brian L. Penza, D.O., (left), instructor, Department of Internal Medicine.

Eimerbrink Memorial Award
Presented to Kyle Hummerston, D.O., by Evan Nicholas, D.O., (right), associate professor, Department of Osteopathic Manipulative Medicine (OMM).

Finkelstein Award
Presented to Christopher Parker, D.O., by Leonard H. Finkelstein, D.O. (left), PCOM chancellor.

Flack Memorial Award
Presented to Joana Catalano, D.O., by Daniel J. Parenti, D.O., chairman, Department of Internal Medicine, and professor of pulmonary and critical care medicine.

Ginsburg Humanitarian Award
Presented to Michael Stefanowicz, D.O., by Jay S. Feldstein (left), Dr. Susan Apollon, and her daughter Dr. Rebecca Apollon (right).

Kanoff Memorial Award
Presented to Joshua DaSilva, D.O. (center), by Michael A. Becker, D.O., vice chairman and associate professor, Department of Family Medicine, and Lauren Noto-Bell , D.O., assistant professor, Department of OMM.

Lutz Memorial Award
Presented to Gregory Gilson, D.O. (right), by Pat A. Lannutti, D.O., chairman, Division of General Internal Medicine.

Donna Jones Moritsugu Award
Presented to Jason Talley by Denise Curran, director of student affairs administrative services, coordinator of disability services.

OMM Fellows
Presented to (front left to right) Kyle Hummerston, D.O., Daniel Nguyen, D.O., and Brianna Hitchner, D.O., by (back left to right) Drs. Allison, Noto-Bell, Hobson and A. Nicholas of the Department of OMM

PCOM Student Memorial Award
Presented to Justin Ross, D.O., by Brian Balin, Ph.D. (right), chairman, Department of Bio-medical Sciences.

Rogove Memorial Award
Presented to Seng Hue Joshua Foong, D.O., by Katherine E. Galluzzi, D.O., professor and chair, Department of Geriatrics.

Sterrett Memorial Award
Presented to Emily Kemner-Kozlowski, D.O., by Laurence H. Belkoff, D.O., chairman, Division of Urologic Surgery.

Vickers Family Practice Award
Presented to Chelsea Ryan, D.O. (left), and Jessa Landers, D.O., by Harry J. Morris, D.O., professor and chairman, Department of Family Medicine.

Wheeler Memorial Award
Presented to Shqiponja Dervishaj, D.O. (right), by Madelyn Sine-Karasick, D.O., professor, Department of Radiological Sciences.

Galen S. Young, D.O., Memorial Award
Presented to Robyn Daiber, D.O., by Joseph P. Guagliardo, D.O., professor, Department of Surgery.

Jesse M. Young Memorial Award
Presented to Michael Stefanowicz by Richard A. Pascucci, D.O., vice dean for clinical education and chief academic officer for PCOM MEDNet.

Professor Emeritus
Presented to Saul Jeck, D.O.

Professor Emeritus
Presented to Tage N. Kvist, Ph.D. (right), by Dr. Feldstein.

2016 Osteopathic Graduates

Arizona

A.T. Still University —
School of Osteopathic Medicine in Arizona

ATSU-SOMA graduated 101 new D.O.s from its sixth class during a ceremony on May 20, 2016, at the Mesa Arts Center. Darrell Lynn Grace, D.O., a hospitalist at St. Elizabeth Hospital in Youngstown, Ohio, who also helped establish Grace Place Medical Service in Youngstown, served as keynote speaker.

Arizona

Arizona College of Osteopathic Medicine
of Midwestern University

Two hundred fifty-seven new D.O.s received their degrees during AZCOM's commencement ceremony, held June 1, 2016, in the auditorium on Midwestern University's Glendale campus. President and CEO Kathleen H. Goeppinger, Ph.D., provided remarks.

California

Touro University College
of Osteopathic Medicine

On May 31, 2016, TUCOM welcomed 133 new D.O.s into the osteopathic family during its commencement at Zellerbach Hall on the UC Berkley campus.

California

Western University of Health Sciences —
College of Osteopathic Medicine of the Pacific

On May 20, 2016, COMP held its 35th annual commencement at the Pasadena Civic Center, where 208 graduates were welcomed into the osteopathic family. David S. Blatt, M.D., Ph.D., global head of neuroscience discovery for Johnson & Johnson Pharmaceutical Group, provided the keynote address.

Colorado

Rocky Vista University College of Osteopathic Medicine

On May 21, 2016, RVUCOM bestowed the D.O. degree on 151 graduates during commencement ceremonies at the Ellie Caulkins Opera House in Denver, Colorado. Boyd R. Buser, D.O., 2016-2017 AOA president, was the commencement speaker.

Florida

Lake Erie College of Osteopathic Medicine — Bradenton Campus

LECOMB graduated its ninth class of osteopathic physicians during commencement exercises held at the Bradenton Area Convention Center in Palmetto, Florida, on June 5, 2016. One hundred ninety new physicians received their D.O. degrees.

Florida

Nova Southeastern University — College of Osteopathic Medicine

NSUCOM conferred D.O. degrees upon 234 graduates during commencement exercises held on May 20, 2016, at The Arena at the Don Taft University Center on NSU's main campus in Fort Lauderdale, Florida. Congressman Theodore E. Deutch served as the keynote speaker.

Georgia

Georgia Campus — Philadelphia College of Osteopathic Medicine

GAPCOM graduated its eighth class of D.O.s on May 27, 2016. One hundred twenty-one new osteopathic physicians received their degrees during ceremonies held at the Infinite Energy Center in Duluth. The commencement address was provided by John R. Potts, III, M.D., senior vice president for surgical accreditation at the Accreditation Council for Graduate Medical Education.

2016 Osteopathic Graduates

Illinois

Chicago College of Osteopathic Medicine of Midwestern University

On May 26, 2016, CCOM held commencement exercises for 200 D.O. graduates on the Downers Grove Campus. Kathleen H. Goeppinger, Ph.D., president and CEO of Midwestern University, led the ceremony.

Iowa

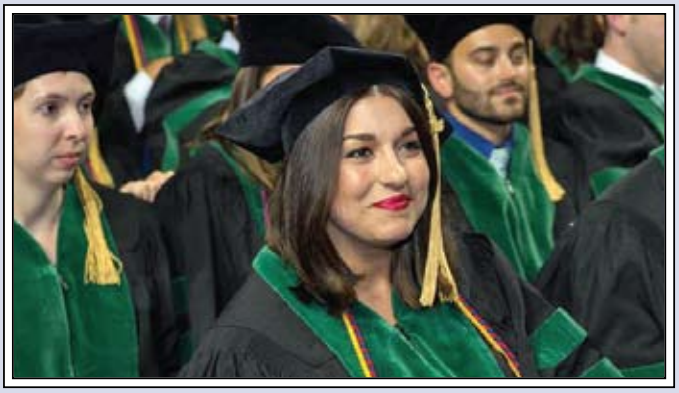
Des Moines University — Osteopathic Medical Center College of Osteopathic Medicine and Surgery

DMUCOMS welcomed 212 new D.O.s into the osteopathic family during its commencement ceremony, held May 28, 2016, at the Wells Fargo Arena in Des Moines. Louis W. Sullivan, D.O., who served as secretary of the U.S. Department of Health and Human Services under President George H. Bush, presented the keynote address.

Kentucky

University of Pikeville — Kentucky College of Osteopathic Medicine

KYCOM conferred degrees on 124 new D.O.s during its 16th annual commencement ceremony, held May 14, 2016, at the East Kentucky Expo Center in Pikeville. John W. Becher, D.O., 2015-2016 AOA president, delivered the keynote address.



Maine

University of New England College of Osteopathic Medicine

UNECOM held its 181st commencement ceremony on May 21, 2016, at the Cross Insurance Arena in Portland, Maine. Dr. Robert Michael Franklin, Jr., Laney professor of moral leadership at Emory University in Atlanta, Georgia, presented the commencement address to 124 D.O. graduates and their family and friends.

Michigan

Michigan State University College of Osteopathic Medicine

On May 5, 2016, MSUCOM welcomed 294 graduating D.O.s. The ceremony featured Wolfgang G. Gilliar, dean of the New York Institute of Technology College of Osteopathic Medicine and MSUCOM alumnus. The event was held at the MSU Breslin Student Events Center in East Lansing.

Mississippi

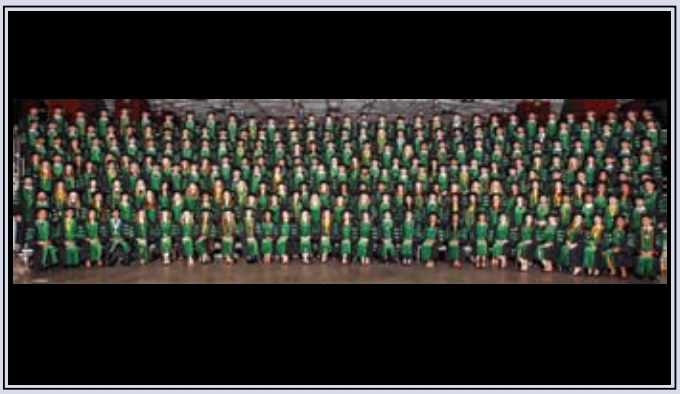
William Carey University College of Osteopathic Medicine

WCUCOM welcomed approximately 100 new D.O.s to the osteopathic family during its third commencement ceremony on May 21, 2016. The event was held at Smith Auditorium in Hattiesburg, Mississippi.

Missouri

A.T. Still University of Health Sciences Kirksville College of Osteopathic Medicine

KCOM conferred D.O. degrees upon 167 graduates during commencement exercises, held May 14, 2016, at Baldwin Hall Auditorium at Truman State University in Kirksville. Suzanne R. Steinbaum, D.O. (KCOM '94), presented the commencement address. Dr. Steinbaum is director for women and heart health at The Heart and Vascular Institute at Lenox Hill Hospital in New York.



Missouri

Kansas City University of Medicine and Biosciences — College of Osteopathic Medicine

KCUMB-COM conferred 245 D.O. degrees during commencement ceremonies on May 7, 2016, at Municipal Auditorium in Kansas City, Missouri. Fitzhugh Mullan, M.D., Murdock head professor of medicine and health policy at George Washington University, provided the keynote address during the college's centennial commencement.

2016 Osteopathic Graduates

Nevada

Touro University Nevada College of Osteopathic Medicine

On May 15, 2016, TUNCOM welcomed its newest D.O.s into the osteopathic family during commencement ceremonies at the Rio Hotel and Casino in Las Vegas, Nevada. One hundred twenty-five physicians received their osteopathic medical degree during the college's 11th annual commencement.

New Jersey

Rowan University School of Osteopathic Medicine

RUSOM conferred 160 D.O. degrees during its 36th annual convocation ceremony on May 13, 2016, held on the Glassboro campus. John W. Becher, D.O., AOA 2015-2016 president, addressed the new physicians.

New York

New York College of Osteopathic Medicine of New York Institute of Technology

Two hundred ninety D.O. graduates were hooded at the Tilles Center for the Performing Arts in Brookville, New York, on May 23, 2016. Keynote speaker Christine K. Cassel, M.D., planning dean of the Kaiser Permanente School of Medicine, stressed that the class of 2016 was about to jump into "a river of change."

New York

Touro College of Osteopathic Medicine

TOUROCOM welcomed its sixth class on June 2, 2016. One hundred twenty-three new physicians received their D.O. degrees during commencement ceremonies health at the Apollo Theater in Harlem. Ramanathan Raju, M.D., president and CEO of NYC Health + Hospitals, provided the keynote address.

Ohio

Ohio University Heritage College of Osteopathic Medicine

On May 7, 2016, OUHCOM graduated 129 new osteopathic physicians during its 37th commencement ceremony, held at the Templeton-Blackburn Alumni Memorial Auditorium in Athens. Ronald C. Mooman, D.O. (OUCOM '80), a psychiatrist and flight surgeon at NASA's Johnson Space Center in Houston, Texas, addressed the graduates.

Oklahoma

Oklahoma State University Center for Health Services — College of Osteopathic Medicine

OSUCOM welcomed 108 new D.O.s during commencement exercises held on May 6, 2016, at the Gallagher-Iba Arena in Stillwater, Oklahoma.

Oregon

Western University of Health Sciences' College of Osteopathic Medicine of the Pacific — Northwest

On June 3, 2016, COMP-Northwest graduated 105 new D.O.s during their second commencement ceremony on the college's campus. Lori Sobelson, director of corporate outreach at Bob's Red Mill Natural Foods, a dedicated supporter of the college and its medical mission, provided the keynote address.

South Carolina

Edward Via College of Osteopathic Medicine — Carolinas Campus

VCOM-Carolinas welcomed 153 new osteopathic physicians into the profession during their second commencement ceremony on May 21, 2016, at the Spartansburg Memorial Auditorium. Oscar Lovelace, M.D., 2015 South Carolina FP of the Year, was the commencement speaker.

2016 Osteopathic Graduates

Tennessee

Lincoln Memorial University — DeBusk College of Osteopathic Medicine

On May 14, 2016, LMUCOM graduated 181 D.O.s in its sixth class. Commencement ceremonies were held at the Tex Turner Arena on the LMU main campus in Harrogate, Tennessee. Sister Anne Eucharista Brooks, SNJM, D.O., medical director and chief administrator of the Tutwiler Clinic, delivered the commencement address.

Texas

University of North Texas Health Science Center — Texas College of Osteopathic Medicine

TCOM held its 43rd annual commencement ceremony on May 21, 2016, at TCU's Schollmaier Arena. TCOM welcomed 216 new D.O.s to the osteopathic family.

Virginia

Edward Via College of Osteopathic Medicine — Virginia Campus

On May 7, 2016, VCOM welcomed its 10th class of D.O.s into the osteopathic family during commencement ceremonies at Burruss Hall on the campus of Virginia Tech. VCOM conferred 172 D.O. degrees. William G. Anderson, AOA past president and early civil rights leader, was the commencement speaker.

Washington

Pacific Northwest University of Health Sciences — College of Osteopathic Medicine

PNWU-COM welcomed its fifth class of D.O.s during a commencement ceremony held at the Capitol Theater in Yakima, Washington, on May 21, 2016. Mary C. Selecky, Secretary of Health (ret.), provided the keynote address for the college's 72 newest osteopathic physicians.

West Virginia

West Virginia School of Osteopathic Medicine

On May 28, 2016, WVSOM held its 39th annual commencement ceremony on the school campus in Lewisburg. John W. Becher, D.O., AOA 2015-2016 president, delivered the keynote address to WVSOM's 183 new D.O.s.

POFPS 41st Annual CME Symposium Draws Record Attendance!

Once again, the POFPS symposium broke all attendance records! The POFPS 41st Annual CME Symposium, held August 5-7, 2016, at the Hershey Lodge in Hershey, Pennsylvania, was a huge success, with over 450 registered physicians attending the meeting. Sponsored by the POMA Foundation, a total of 20 Category 1A AOA CME credits were available to physicians who attended all of the lectures.

This year's VIPs included Carol L. Henwood, D.O., F.A.C.O.F.P. *dist.*, past president of the American College of Osteopathic Family Physicians and the POFPS; Robert R. Rodak, D.O., F.A.A.F.P., president of the Pennsylvania Academy of Family Physicians; and POMA President Anthony E. DiMarco, D.O., F.A.C.O.F.P.

Fifteen exhibitors were on hand to showcase their products and answer physicians' questions. The POFPS would like to thank this year's exhibitors for their support:

AbbVie, Inc.
Allergan, Inc.
Amarin Pharma, Inc.
American College of Osteopathic Family Physicians
ARPwave, LLC
Cancer Treatment Centers of America
Correct Care Solutions, LLC
Iroko Pharmaceuticals, LLC
Kowa Pharmaceuticals America, Inc.
Mercer-Bucks Orthopaedics
Novartis Pharmaceuticals Corporation
Nu Skin
Patient First
Pfizer, Inc.
True Health Diagnostics, LLC

The POFPS would also like to thank Amarin Pharma, Inc., ARPwave, LLC, and Legally Mine for their contributions to support the meal functions.

The POMA Foundation would like to thank the American Osteopathic Association and Cancer Treatment Centers of America for their contributions to the educational program.

Symposium program chairman Deanne S. Endy, D.O., is to be commended for a job well done! The success of this year's program was a result of her hard work and incredible effort.

The POFPS board of trustees also held a meeting during the symposium, with President Richard A. Ortoski, D.O., presiding. This year's VIPs brought greetings from their respective associations. The board also received activity updates from the student association chapters of the ACOFP. SAACOFP chapter president Marsha Dietrich-McLean, OMS-II, represented the Lake Erie College of Osteopathic Medicine, and SAACOFP chapter president Morgan A. McCoy, OMS-II, represented the Philadelphia College of Osteopathic Medicine. Both chapters are very active on their respective campuses and are looking forward to recruiting first-year students this fall.

This year's symposium also featured the inaugural student program, which was followed by a networking reception and dinner. As members of the POFPS mentor program, eight students from the Lake Erie College of Osteopathic Medicine and four students from the Philadelphia College of Osteopathic Medicine attended the program and dinner.

Coordinated by Jessica L. Masser, D.O., a POFPS board member and faculty member of Conemaugh Health System Family Medicine Residency Program, the student program featured four family medicine residency program directors who addressed various components of the transition from medical school to residency training.

Dr. Masser is to be applauded for organizing an outstanding inaugural student program. The POFPS also thanks the Conemaugh Health System Family Medicine Residency Program and the Washington Health System Family Medicine Residency Program for their generous contributions to the student program and dinner.

OUT OF MY MIND

Samuel J. Garloff, D.O.

Samuel J. Garloff, D.O.

Gentle reader: a word of caution. Those who know me and know me well realize my love for music, literature and live theater. During periods of reflection, angst, doubt, despair or turmoil, I find comfort in one or all of them. Why you may ask? I believe the answer to be simple. The arts and humanities contain all the nuances of human emotion and strength.

In 1887, A.E. Housman published a collection of poetry entitled the Shropshire Lad. One untitled entry has now become known as "When I Was One-and-Twenty."

When I was one-and twenty
I heard a wise man say,
"Give crowns and pounds and guineas
but not your heart away;
Give pearls away and rubies
but keep your fancy free."
But I was one-and-twenty,
no use to talk to me.

Early in a man's life, love is given and taken freely. There is love of God, love of country, love of family. Often this is followed by love of humanity, education, the arts, the sciences, ideals and visions of the future. Soon this is followed by love of a partner or spouse, children and grandchildren.

If we are fortunate, we will find a calling to love and cherish equally as great as those above. Like you, I have been fortunate. I have been able to sustain and expand my love for this noble profession of osteopathic medicine. I think of myself as an osteopathic physician who practices psychiatry. Not a psychiatrist who happens to be a D.O. In reading the teachings of Andrew Taylor Still, I sense in him an understanding of mankind, its frailties and courage, that rivals the insights of any psychoanalyst I have ever studied.

We are now at the intersection of a new stage in the evolution of our profession. Several changes are afoot. Like all periods of change, there exists equal opportunity for success and failure, growth and regression, and the ability to propel our profession or become so intermingled as to lose our distinctiveness and identity. It is time for us to unite. There is no old guard and there is no new guard. There is only a cadre of dedicated men and women of our profession to carefully frame, protect and preserve this wonderful profession of osteopathic medicine for the future and the betterment of our patients.

When I was one-and-twenty
I heard him say again,
"The heart out of the bosom
was never given in vain;
'Tis paid with sighs aplenty
and sold for endless rue."
And I am two-and-twenty,
And oh, 'tis true, 'tis true.

A STUDENT'S VOICE *(continued from page 9)*

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3. The Arc: Civil rights issues for people with disabilities. 2016. Retrieved from *http://www.thearc.org/what-we-do/public-policy/policy-issues/civil-rights*.

4. Ali A, Scior K, Ratti V, et al: "Discrimination and other barriers to accessing health care: perspectives of patients with mild and moderate intellectual disability and their careers." PLoS ONE. Retrieved from *http://dx.doi.org/10.1371/journal.pone.0070855*.

CME Quiz

Name _____

AOA # _____

1. Athletes of the Ontario Hockey League surveyed on intentional injuries in sports agreed that non-accidental injuries target:
   a. younger opponents
   b. influential opponents
   c. weaker opponents
   d. rookie opponents

2. The majority of Ontario Hockey League athletes surveyed felt that they had been targets of intentional injurious action.
   True False

3. What trend was seen in injury rates from Division III to Division I athletics?
   a. an increase in injury rates
   b. a decrease in injury rates
   c. no trend
   d. this trend was not studied

4. There was a statistical difference between college and professional athletes when asked, "Have you ever withheld telling your coach/trainer that you were injured?"
   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. Upon receipt of the quiz, we will forward it to the AOA CME Department. You will receive two Category 2B AOA CME credits. Please include your AOA number.*

Answers to Last Issue's CME Quiz

1. b
2. a
3. a,b,d,e
4. true

(Questions appeared in the June 2016 Journal.)