

Standardization of the hospital record for osteopathic structural examination: Part 2

Effects of an educational intervention on documentation of palpatory and structural findings and diagnosis

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The purpose of this two-part study was to develop and test an instructional videotape for use in the osteopathic hospital setting; to standardize a procedure for documentation of palpatory and structural findings and diagnoses; and to examine the program's influence on the correlation of palpable and structural findings with a diagnostic impression of somatic dysfunction. To that end, the authors analyzed results of a survey of the medical records of 20 osteopathic training hospitals. Patients' charts were randomly pulled before and after house staff who performed admitting hospital examinations viewed an educational videotape. The videotape emphasized that the structural and palpatory screening examination should simply answer the question, "Is there a problem in the musculoskeletal system?"

Chi-square analysis was used to evaluate the frequency of documentation of altered structural findings (structure, motion, tissue changes) and the diagnostic impression of somatic dysfunction and their correlation. Based on more than 300 reviewed charts, the authors found that the frequency of documentation of structural and palpatory examination was not significantly altered after house staff viewed the videotape. A sequence of hospital-based instruction in osteopathic principles and practices has been initiated at more than 50 osteopathic medical institutions, and the problems related to continuing medical education and clinical research in osteopathic medicine are discussed.

(Key words: Continuing medical education, structural and palpatory examination, musculoskeletal examination, somatic dysfunction)

Progress made in documenting structural and palpatory examination procedures and findings has been reviewed.¹⁻²³ All osteopathic medical

students are familiar with the structural examination procedure and the tests used to confirm the presence or absence of somatic dysfunction. It is recognized that procedures are performed in a logical sequence and findings are recorded to document:

- specific signs that a problem exists within the musculoskeletal system;
- location of identified problems; and
- definition of those problems' characteristics.

Conducting a musculoskeletal examination that documents and describes the testing procedures performed and the criteria used for determining positive findings establishes a consistent, reliable

protocol with which a standardized record can be developed. The diagnosis of somatic dysfunction is determined by tests assessing the patient's motion response, tissue texture characteristics, and asymmetry of bony and soft tissue position. Many testing procedures conducted by osteopathic physicians and the criteria established for positive findings have been clinically investigated and documented. Identification of the specific findings characterizing dysfunction contributes to diagnostic impressions and the application of a rational treatment plan.

Pilot study: Methods

Our study of standardization of hospital records for palpatory and structural examination was staged over a 3-year interval. In year 1, an initial pilot study by Friedman and colleagues²⁴ was conducted because there had been no published data on the frequency of documenting the palpatory findings or diagnosis of somatic dysfunction in patients undergoing hospital admitting examinations. Nor was there any published data on the influence of using a standardized protocol for documenting the frequency of findings or the diagnosis of somatic dysfunction (or both).

Historically, osteopathic hospital participation in multiple-site data collections such as the one reported here has been limited. The pilot study²⁴ entailed contacting 112 osteopathic hospitals via a letter to each of the directors of medical education (DMEs). Additionally, the American Osteopathic Hospital Association (AOHA) and department of medical records at each individual hospital were also contacted. As a result, 24 DMEs and their corresponding hospitals agreed to participate in our pilot study. Yet, data were received from only 7 of the 24 hospitals. Charts from these seven institutions were randomized into study and control groups. The study group used a standardized record that logically identified the absence or presence of the palpable spinal findings of motion, tissue tension, and structural asymmetry to support recording the absence or presence of a diagnosis of somatic dysfunction.

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The control group received no standardized record materials.

Results from this pilot study showed that 96% of the charts in the study group had documented at least one of the findings described; 94% of the charts in the study group had reported the presence or absence of somatic dysfunction. Only 62% of the charts in the control group had documented one of the palpatory findings; 25% reported the absence or presence of somatic dysfunction.

Use of a standardized protocol for palpatory and structural examination in this pilot study showed a greater frequency of documentation with a higher correlation of a diagnosis of somatic dysfunction.

Year 2 of the study addressed the logical correlation of palpatory and structural findings with the documentation of a diagnostic conclusion of somatic dysfunction. The current structured narrative format used as part of the admitting hospital record in all osteopathic hospitals has a provision for documenting palpatory and structural findings and diagnoses. However, Seffinger and colleagues²⁵ found this format underused in a multi-site survey of osteopathic hospitals' records.

Current study: Methods

The current project (year 3)²⁶ reported here continues the development of a standardized medical record procedure that documents palpatory and structural findings and diagnoses. The purpose of this documentation is to establish multiple-site data-collection capabilities in osteopathic medical research. The purpose of this study was to develop a core instructional unit covering the principles and procedures for documentation of palpatory and structural findings and diagnosis in order to study its influence on the recording of palpable findings and their correlation with diagnostic impressions on the hospital admitting examination.

The educational arm of this study included a 15-minute videotape and accompanying handout (*Appendix A*). Considerable effort was devoted to simplifying and communicating the essential aspects of record keeping. The handout to accompany the videotape viewing is included to illustrate the methods of our

educational model. Faculty and participants in the videotape viewing were asked to complete a feedback questionnaire.

The current study was conducted in 1989–1990. All the osteopathic training hospitals listed in the *Yearbook and Directory of Osteopathic Physicians 1988* were asked to participate in the study, as was the case in year 1 and year 2 of the study. The hospitals were to provide a written agreement to participate and comply with the research protocol. All data photocopied from the hospitals' medical records were sent to the data collection center at the American Academy of Osteopathy (AAO). The patients' name, address, and social security number, as well as any other identifying data were omitted. No examiner, physician, or hospital name was present on any of the data collected. Selected medical records photocopied included the hospital admitting examination and discharge sheet that listed the patient's primary, secondary, and additional diagnoses of musculoskeletal disorders.

Exclusion of records was determined by the investigator and was based on examinations performed by other than osteopathic interns or medical students or those examinations in which the patient could not assume a seated position. Data was identified by a hospital code (not by name). The code was assigned and kept by an AAO staff member and was unknown to the investigators. Each hospital kept a list of those records sent to the AAO in case a repeat sample was needed.

Charts were randomly selected from daily admitting records for surgery and medical admissions only, beginning on September 20, 1989. Every 20th admission was selected for data collection until 40 records had been selected. The sample size was matched with that of the random charts collected from year 2 of the study. These charts served as the control sample for the current study. Only those sites in common with those in the previous year's study were used for comparative analysis in the current study. The 15-minute videotape was presented to the students and interns as part of their orientation during June to July 1989. Data were examined using χ^2 analysis for the

frequency with which palpable findings and the diagnosis of somatic dysfunction appeared on the hospital admitting examination chart.

Results

A total of 179 osteopathic hospitals were asked to participate; 59 (32.4%) responded. Of these, 37 (63.8%) provided the instructional portion used in the videotape. Of these, 20 returned copies of patients' medical records for use in analysis by the AAO data collection center. More than 700 examinations were received overall from these 20 hospitals. However, only 8 (40%) of the 20 hospitals matched the sites used in the pilot study. These eight sites provided 302 records, compared with 273 records used as the control group in the previous year's study.

Using χ^2 analysis, we found *no* significant difference in the documentation of palpatory and structural findings and diagnoses before and after participation in the videotape program (*Figure 1*). However, participation did show a trend of *increased* documentation of positive palpatory and structural findings in patients undergoing hospital admitting examinations. Similarly, a *decrease* in the number of records that lacked notation of such an examination was also found. The records from the 12 nonqualifying osteopathic hospitals reflected similar trends.

Discussion

This current study:

- establishes an instructional intervention videotape program that communicates the principles of performing and recording a palpatory and structural screening examination on patients being admitted to the hospital;
- tests a research protocol for implementing educational intervention for use in standardizing the record keeping of results from palpatory and structural examinations;
- generates statistically based data on the need for improving documentation of palpatory and structural findings, impressions, and therapeutic interventions in the evaluation and management of hospitalized patients; and
- establishes a working model for a per-

Frequency of Documentation of Structural and Palpatory Findings and Diagnosis in Medical Records

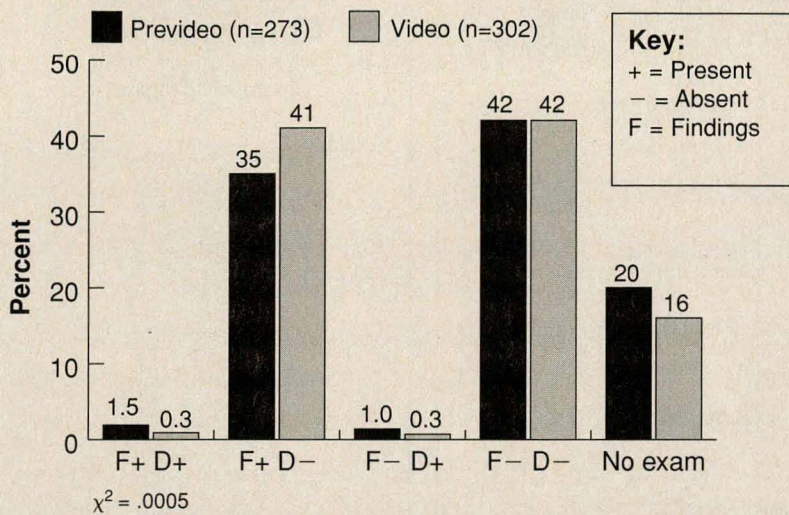


Figure 1. Comparison of control data with data following videotape viewing.

manent multiple-site data-collection mechanism in osteopathic medical research.

Educational intervention

The videotape and handout material emphasize that the palpatory and structural screening examination should simply answer the question, "Is there a problem in the musculoskeletal system?" If yes, then the operator also needs to determine regionally where the problem is located. The screening examination should establish only if a problem exists. Any subsequent follow-up might include the need to consult an osteopathic manipulative medicine specialist to make a definitive diagnosis and clinical management recommendations.

The videotape itself presents a format for documenting findings and impressions in a region-by-region manner, listing positive and negative findings as well as a regional diagnosis of somatic dysfunction in the patient's medical problem list. The manner of testing region-to-region was left up to the individual operator performing the examination. The tests used were intended to elicit the following minimal criteria for making a diagnosis of somatic dysfunction: *altered structure and/or gross motion plus tissue texture abnormalities*. A segmental anal-

ysis at the time of the screening examination was not required. Regional documentation of altered findings should correlate with the diagnosis of regional somatic dysfunction in the medical problem list and on the discharge face sheet.

This documentation was to ensure that somatic dysfunction receives consideration and follow-up management similar to that given other problems identified at the time of the admitting examination. Standardized records of all medical conditions help to ensure quality healthcare as well as to establish accurate records for research, data collection, and statistical compilation.

Feedback

Included in the instruction materials was a feedback sheet for participating interns and students to respond to the overall study and the education portion. Based on these responses and discussions with participants, we discovered that actual implementation of the instructional portion of this study was impeded by unsupervised viewing, lack of handouts, malfunctioning videotapes, lack of a follow-up practice session for performing the structural examination, and lack of reinforcement of those points made in the educational program during hospital rounds.

Overwhelmingly, participants reported a concern for the lack of role models who practice osteopathic principles in the hospital environment. They thought that this lack of mentors contributed to the overall unsupportive environment in which osteopathic principles and practices could be nurtured. The major focus of this study was to underline the importance of a uniform record for documenting palpatory and structural findings and diagnoses and their relationship to the patient's overall management. Standardized documentation serves as a fundamental step toward improving the recording practices of osteopathic hospitals.

In our year 2 portion of the study, we learned that the reporting of palpatory and structural findings and diagnoses on admitting hospital examinations was less than optimal. Yet, in year 1 of the study, we demonstrated that the reporting of palpatory and structural findings and diagnoses *could* be improved by having examiners attend to the principles developed for performing a standardized examination.

The current study (year 3) further developed an educational intervention designed to have an even greater influence on the reporting of palpatory and structural findings and diagnoses. However, the educational component developed for this study was not effective in accomplishing this objective.

The difference between the documentation results of the pilot study and those of the current one may be related to the personal contact made with the hospital representative at each research site. In the pilot study, this person was an acquaintance of ours, usually an intern whom we had handpicked because of his or her demonstrated interest in osteopathic principles and practices as well as an interest in the objectives of this study.

In the current study, the contact person was the DME with whom we spent less time cultivating personal involvement and more time developing the educational program and the procedure for its implementation. Unfortunately, many problems arose in implementing the videotape program, as previously mentioned. Maybe the interns in the pilot study felt

Palpatory and Structural Examination

Body region	Altered findings			Somatic dysfunction
	Structure	Motion	Tissue	
Head/face				
Cervical				
Thoracic				
Lumbar				
Sacropelvic				
Costal cage				
Extremities				
upper				
lower				

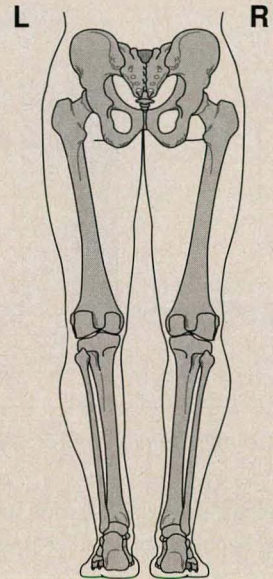
Comments:

Key:

- + = Presence of altered findings/somatic dysfunction
- = Absence of altered findings/somatic dysfunction
- O = Omitted

Record of Palpable Regional Abnormalities

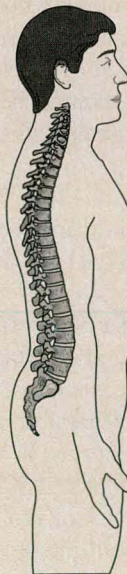
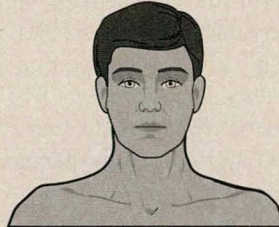
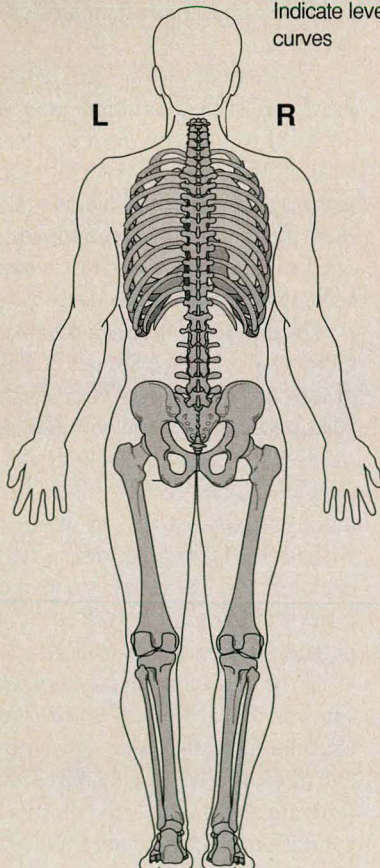
Sacropelvic region



Indicate tissue texture changes as X and resisted motion as →| in the sacropelvic region and the cervico-thoracic region.

Record of Gross Visual Anatomy

Indicate levels of asymmetry as high ↑ or low ↓ and curves



Spinal and costal region

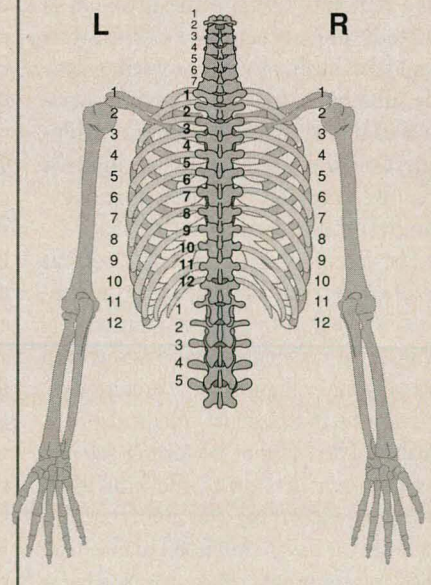


Figure 2. Form for recording results of hospital-admitting palpatory and structural screening examination.

more of an obligation to succeed because they had a personal vested interest. In the current study, hospitals were not identified and, therefore, their interest was not personalized.

Furthermore, as shown in results from the year 2 arm of the study, the osteopathic medical principles presented for recording palpatory and structural findings and relating those findings to the patient's complaints are *not* part of routine hospital practice. The data collected in both year 2 and year 3 suggest that correlation of palpatory and structural findings and diagnoses does not frequently appear in the records of osteopathic hospitals. It is difficult to expect an educational project of this type to succeed without appropriately training educators responsible for its implementation. Our mistake was in overestimating the general understanding of these principles in the osteopathic hospital environment. Future efforts should involve more faculty who understand these principles and who can communicate them to persons involved in program implementation.

Suggestions for improving documentation and data collection

We offer the following suggestions for improving multisite data collection in osteopathic medical research as well as enhanced compliance by hospitals in documenting palpatory and structural findings in patients undergoing a screening examination for hospital admission.

■ Designating one person responsible for training house staff in performing and recording a standardized palpatory and structural examination. This person would be responsible for implementing clinical research in osteopathic manipulative medicine, and establishing and supporting a department of osteopathic manipulative medicine at every hospital.

■ Establishing more stringent requirements for continued hospital accreditation. For example, it should be required that documented positive findings be correlated with a documented diagnosis of somatic dysfunction. Furthermore, the treatment of somatic dysfunction should

be addressed in the patient's management plan.

■ Developing a database that correlates osteopathic medical records with health-care outcomes in osteopathic medical practice. With the implementation of a standardized record, multisite data collection can begin to generate outcomes studies, which are essential if the osteopathic medical profession is to develop clinical practice parameters.

■ Improving the educational program first used in this study, specifically upgrading the quality and completeness of the videotape program and the accompanying handout. Some suggestions include a training session for educators responsible for implementing the program; more detailed palpatory and structural evaluation of debilitated patients; and a completed sample of a hospital record entailing results from a palpatory and structural examination.

Besides these suggestions, we include an on-site training manual (*Appendix B*) for use in further implementing a standardized record for documenting osteopathic medical care received during the hospital admitting examination (*Figure 2*). This training manual is based on what we have learned from this study.

Comment

Manual medicine is gaining wider acceptance among allopathic physicians. This acceptance places the osteopathic medical profession in the unique position of setting the example for the rest of the medical community to follow. Parameters for osteopathic medical education and certification are already being set, but clinical practice and research standards lack the most basic ingredients—a uniform record-keeping system and the use of a multisite data-collection mechanism. Both of these issues have been addressed in this current project. Both are in need of continued support to ensure that the osteopathic medical profession continues a leadership role in the field of manual medicine. The key to this support is the documentation of not merely the presence or absence of palpatory and structural findings, but the correlation of the diagnostic impression of somatic

dysfunction with the patient's complaints and overall management plan. In other words, we have to practice what we preach or risk losing our uniqueness as osteopathic physicians.

Acknowledgment

This study was supported by the Burroughs Wellcome Osteopathic Fellowship, the American Academy of Osteopathy, the Chicago College of Osteopathic Medicine Midwestern University, American Osteopathic Association of Directors of Medical Education, American Osteopathic Hospital Association, and department of medical records at cooperating osteopathic medical institutions.

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Appendix A: Standardized Record for Documenting Results of the Palpatory, Structural Screening Examination

Handout to accompany videotape

This educational program outlines the basic components for standardized recording of results from a palpatory and structural screening examination performed on patients being admitted to the hospital. Principles for performing and recording results from the examination are emphasized. Specific examples are provided; however, this program communicates only *what* to do, *not* how to perform the examination. The specific content and order of the examination procedures are up to the trainer's discretion.

This program demonstrates how palpatory and structural diagnosis and treatment can be integrated into clinical problem solving and patient management. Clarifying the purpose and logic of the examination as well as simplifying the procedures used enables results from the palpatory and structural examination to be recorded in a standardized fashion.

I. Glossary of terms

Somatic dysfunction: syndrome characterized by musculoskeletal findings of altered structure or motion (or both), plus tissue texture changes indicating the presence of a physiologic disturbance in the regulatory mechanisms of the body

Motion: observation of dynamic posture (such as gait) and palpation of active or passive motion (or both) for range and quality of movement

Tissue: observation and palpation for tissue changes in skin color, temperature, moisture, and cutaneous, subcutaneous, and deep tissue texture; superficial and deep tissue tensions, and tenderness to palpatory pressure

Structural screening examination: initial examination in a series that identifies possible presence of regional musculoskeletal problems related to somatic and visceral structure and function

Structural segmental examination: specific segmental alteration in structure or motion (or both) and tissue; examination may also identify osteopathic manipulative treatment (OMT) appropriate for managing the somatic component of the patient's health problems; segmental structural examination usually accompanies OMT

Screening examination and record

A. Principles

1. Perform examination.
2. Record findings.
3. Decide if somatic dysfunction is present.
4. Record somatic dysfunction (if present) on problem list.
5. Relate somatic dysfunction diagnosis to patient's overall treatment plan.

B. Purpose

1. Answers the question, "Is there a problem in the musculoskeletal system that relates to the patient's illness and healthcare?"
2. Serves as database that includes pertinent history, systems review, and palpable findings of structure, motion, and tissue to support diagnosis of somatic dysfunction.
3. Lists somatic dysfunction diagnosis in problem list and relates to patient management in admitting progress notes and orders.

C. Guidelines for performing examination

1. Examine spinal, costal, pelvic regions for altered structure, motion, and tissue; document any omissions, include reasons.
2. Examine patient in at least two different positions.

Appendix A (continued)

3. Develop simple routine of specific tests, criteria for evaluating palpable findings of structure and motion in each body region.
4. Establish evidence of tissue texture changes to further localize problem first identified in regions with altered structure or motion (or both).
5. Record presence or absence (+ / -) of altered structure, motion, tissue by region.
6. Record somatic dysfunction by region if altered structure or motion (or both) plus altered tissue present within that region. (See palpatory and structural examination form.)
Altered structure or motion (or both) + altered tissue = Somatic dysfunction
7. Ten regions of ICD-9-coded diagnoses of somatic dysfunction exist: head, *cervical*, *thoracic*, *lumbar*, *sacral*, *pelvic*, upper extremity, lower extremity, *costal*, and abdomen; italicized regions represent the minimum of regions that should be included in screening examination.
8. Palpatory and structural findings can be recorded via dictation or handwritten notes or diagrams; any abbreviations, symbols used should be defined:

Sample record keeping (abbreviations format)

General: + weight-bearing tests

Cervical: + motion, + tissue C1-2

Thoracic: + structure, + tissue T2-4, T8-10, T12-L2

Lumbar: + motion, + tissue L4-5

Sacral: + motion, + tissue sacral base

Pelvic: + structure, + motion, + tissue PSIS (Rt)

Costal: - structure, - motion, - tissue

Notes

- Kyphosis, lordosis, scoliosis are all structural observations; may be specifically identified by region or noted as "+ structure" regionally.
- Gait analysis is dynamic motion testing; gait abnormality noted by region as such or as "+ motion" in the region observed.
- General tests (weight-bearing or body habitus), though not required, may be recorded as "+" or "-"

Sample record keeping (narrative format)

May be dictated or handwritten.

Palpatory and structural screening examination

General: altered weight-bearing tests

Cervical region: altered motion, altered tissue at C1-2

Thoracic region: altered structure, altered tissue T2-4, T8-10, T12-L2

Lumbar region: altered structure, altered tissue at L4-5

Sacral region: altered motion, altered tissue at sacral base

Pelvic region: altered structure, altered motion, altered tissue at PSIS (Rt)

Key:

+ = presence of altered findings; - = absence of altered findings; Rt = right side.

Costal cage: no altered structure, motion, or tissue

Notes

- Kyphosis, lordosis, scoliosis, and gait analysis identified by region, or by using terms *altered structure*, *altered motion*.
- Briefly describe weight-bearing or other general tests or note results from these tests as normal/abnormal, present/absent.
- At examiner's discretion, other phrases may be used to describe absence or presence of positive findings.

D. Standardized record system: Benefits

1. Improved patient care

- a. Increases frequency of identification of palpatory and structural alterations.
- b. Assists with diagnosis and identifying possible etiologic factors related to patient's health.
- c. Increases prescribed OMT for somatic components present in health and illness.

2. Research

- a. Provides data for national health statistics.
- b. Ensures uniform records in multi-centered clinical trials.

3. Clinical education

- a. Clarifies purpose, emphasizes logic of palpatory, structural examination.
- b. Integrates palpatory, structural findings into clinical problem solving and patient management.

4. Medical economics

- a. May improve healing by potentiating host responses to illness and prescribed medical, surgical interventions.
- b. Often improves patient comfort, compliance.
- c. May reduce length, frequency of hospital stays.

E. Summary

1. Perform palpatory, structural examination; record findings of altered structure, motion, tissue by region.
2. Determine absence or presence of regional somatic dysfunction [altered structure or motion (or both), plus tissue texture changes]; add to patient's problem list.
3. Relate diagnosis of somatic dysfunction in hospital admitting progress notes, orders, and patient's healthcare plan (order an osteopathic medical consultation or order OMT by region to be performed by examiner, other house staff, or student osteopathic physicians).

Accompanying videotape *A Standardized Record for Osteopathic Healthcare: The Screening Exam* and handout intended for undergraduate and postgraduate education. Written permission for other uses should be obtained from the American Academy of Osteopathy, 3500 DePauw Blvd, #1080, Indianapolis, IN 46268.

Appendix B: Training Manual for Implementing Standardized Record for Palpatory, Structural Examination

I. Intended results

- A. Integrate palpatory, structural findings, diagnosis, treatment into clinical problem solving, patient management.
- B. Develop standardized record keeping to document palpatory, structural findings, diagnosis, OMT.
- C. Participate in data-collection survey of medical records to ascertain frequency of documentation of palpatory, structural findings, diagnosis, and effectiveness of educational intervention on increasing frequency thereof.
- D. To have students, interns:
 1. perform examination and record (at least) presence (+) or absence (-) of altered structure, motion, tissue in each spinal, costal, and pelvic region;
 2. ascertain presence of somatic dysfunction (findings of altered structure, or motion (or both), plus tissue texture change; and
 3. record somatic dysfunction in patient's differential diagnosis and in admitting progress notes, orders.

II. Training outline

- A. Provide supervised training for implementing standardized record for palpatory, structural examination at participating hospital sites.
- B. Show videotape to all osteopathic medical students, interns, and any interested residents, attending physicians.
- C. Precede videotape with introduction delivered by training supervisor.
- D. Perform hands-on laboratory exercise with instructions following the videotape.

III. Resource materials

- A. Training manual for on-site training supervisor (this document)
- B. Training session handouts
 1. Sample form to record palpatory, structural findings (Figure 2) (2 copies, one used for hands-on laboratory session, one form completed properly)
 2. Feedback form for attendees to complete; all forms returned to American Academy of Osteopathy (AAO)
- C. Videotape (Additional videotapes are available from AAO, 3500 DePauw Blvd, #1080, Indianapolis, IN 46268; (614) 366-7911)

IV. Scheduling

- A. Arrange 1 hour for videotape training; schedule two meetings to accommodate attendees.
 1. Require all osteopathic medical students, interns to attend.
 2. Invite other residents, attending physicians to attend as time permits.
- B. Choose a meeting room with enough space (and movable chairs) to enable participants to work in pairs to perform the screening examination; for the exercise, the examination will have to be done in the seated and standing positions only.

V. Meeting agenda

- A. Introduction
 1. Distribute handout that accompanies videotape.
 2. Emphasize importance of videotape program.
 - a. Professionwide attempt to standardize the format for recording palpatory and structural findings as part of the hospital-admitting screening examination. Uniformity makes it possible to conduct multiple-site data collections for use in epidemiologic studies and clinical trials in osteopathic medical research and also assists in the effort to coordinate the osteopathic medical curriculum taught at each of the colleges of osteopathic medicine.
 - b. Regional screening examination answers the question, "Is there a problem in the musculoskeletal system?" Detailed segmental examination (for example, T₃FRSRT) not necessary at this time; would accompany treatment at later date. Mere presence of position or gross motion asymmetry, tissue texture changes indicate existing problem. Recording of findings justifies regional impression of somatic dysfunction noted in patient's problem list.
 - c. Opening sequence of videotape depicts a typical musculoskeletal screening examination, but each participant performs his or her own routine after viewing the videotape. Any routine acceptable as long as it includes gross motion or positional testing of each body region and tissue texture evaluated to localize areas where problem identified.
- B. Show videotape. (Make certain both channels A and B are on for proper audio.)
- C. Recap videotape content
 1. Each participant to perform and record results from a complete regional palpatory and structural examination (includes cervical, thoracic, lumbar, sacropelvic, and costal cage regions). Participants need only to perform the examination in the seated, standing positions (no beds or tables available for this exercise).
 2. Record presence or absence of altered motion or structure (or both), plus tissue texture changes and diagnosis of somatic dysfunction region by region.
 3. Standardized form included here can be used *in place of narrative format* normally required for palpatory and structural examination. (Have a completed sample form to show.)
 4. Include any appropriate musculoskeletal diagnosis in patient's problem list and appropriate management plan in admitting notes and orders (such as ordering follow-up OMT or consultation for OMT).
- D. Perform hands-on exercise, complete standardized record form. (Allow 10 minutes for each participant.)
- E. Answer any participants' questions.
- F. Request (or require) that this format for recording results of palpatory and structural examinations be used throughout the training year.