THE JOURNAL of the AMERICAN OSTEOPATHIC ASSOCIATION

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A Degree of Difference: The Origins of Osteopathy and the First Use of the "DO" Designation

To the Editor:

Congratulations to Norman Gevitz, PhD, for furthering our understanding of the role that magnetic healing played in the "evolution of osteopathy" in the special communication that appeared in the January 2014 issue.[1(p34)] Each additional piece of substantiated insight adds to the ever-growing body of knowledge that helps the osteopathic profession better understand how Andrew Taylor Still conceived of and developed osteopathy. However, as Dr Gevitz points out, if a "factually based portrait of the development of osteopathy"[1(p34)] is a goal in this series of articles in *The Journal of the American Osteopathic Association*, then it is worthwhile to examine the criteria for establishing fact in an historical inquiry.

Recognizing that the majority of osteopathic physicians and researchers are not historiographers, several documents outlining historical method could be beneficial to this process. For an overview of the subject, Hodysh's *Theory and Practice in Historical Research*[2] offers a variety of insights into historical methods. Christy's *The Methodology of Historical Research*[3] offers a useful but strict guide for distinguishing fact from probability and possibility. Shafer's *A Guide to Historical Method*[4] provides less exacting delimiters for establishing fact. Shafer also provides approaches for dealing with corroboration and contradiction in historical inquiry. Still's seemingly contradictory statements are highlighted in Dr Gevitz's article.

Christy states that fact is established when 2 independent critically evaluated primary sources agree with each other, or when 1 independent primary source and 1 independent secondary source both are in agreement—and there are no substantive conflicting data.[3] Primary and secondary sources are distinguished by whether the recorded information represents an eyewitness account or someone else's recollection of that first account.[3] Tertiary sources represent information that has gone through more than 2 reporters. Still is an eyewitness to his own accounts, but someone who recounts Still's stories is a secondary source, and someone who relays an account for the third or fourth time is a tertiary source. Any purported "fact" that is based on less than Christy's criteria for establishing fact is either a possibility or a probability. Shafer is not as rigid as Christy, and instead he focuses on degrees of probability, plausibility, and certainty on the basis of such considerations as the personal state of mind of the author, the author's social circumstances, and how the author may be affected by age or illness.[4(pp132-133)]

Together, Hodysh, Christy, and Shafer support that establishing fact in osteopathic history is difficult. It might be more realistic to evaluate osteopathic history in gradations of probability. Evaluation factors affecting the possibility gradient include whether the author accidently or purposefully distorted information, the time span between the event and the reporting of that event, and the intent of the statements under consideration.[4(pp131-138)]

Moreover, the interpretation of historical statements requires examination through several lenses, including the original author's biases as well as the biases of the individual who is now interpreting the truthfulness and value of the original author's words.[4(pp137-138)] For ex-

ample, Still arguably held several biases. He was patriotic, he was spiritual, and he did not want to be held accountable to the "rules of fine writing."[5(p5)] Those biases are evident in the content and style of his writing. In describing Still's writing and actions, Dr Gevitz selected certain adjectives that lend themselves to criticism for their apparent subjectivity. Still is seemingly portrayed in an uncomplimentary light by the use of "entertaining"[1(p30)] to describe his "allusions, parables, tall tales, and allegories"; "unabashedly"[1(p30)] concerning how he made his famous 1874 "banner of Osteopathy" pronouncement; "putative"[1(p32)] regarding his memory of his medical education; and "heretical"[1(p34)] in relationship to his religious beliefs.

From my perspective—which carries its own biases—Dr Gevitz's use of "entertaining" could be replaced with *extensive* to describe Still's allegories, and "tall tales" could be omitted. In describing Still's osteopathy pronouncement, "unabashedly" could be replaced with *bravely*. Still's recollection of his medical education could be described as *indifferent*.

Still openly admitted in his autobiography that his "stories may appear disconnected" because he wrote from memory and that he favored stories that left "lasting impressions on my mind."[5(p5)] Writing at the age of 69 years, he cast doubt on his ability to remember and record the truth. But he did not seem to intentionally conceal the truth. Rather, he admitted that he kept no personal notes of his life, and he did not want to be confined to "dates and figures."[5(p5)] Therefore, it should come as no surprise that he did not chronicle, to our satisfaction, certain aspects of his life's history that the osteopathic profession deems necessary to know today. The evidence regarding Still's attendance at a medical school or college is both corroborative and contradictive[4(pp138-142)]—suggesting that he attended a medical educational institution but revealing doubt as to where and when he attended the institution. According to an undated and unpublished account written by Still that was copied and typed in 1931 by his daughter Blanche Laughlin, Still attended the "Kansas City School of Physicians and Surgeons" (KCSPS) in the early 1860s.[6(p1)] Historical method would dictate that the transcription by Still's daughter of her father's medical education is evidence representing a moderate to strong possibility.

The evidence from Still's daughter seems to outweigh 2 tertiary accounts described in Dr Gevitz's article.[1] In an account published in *The Osteopathic Physician* in 1909—at least 40 years after Still attended medical school—the journal's editor, Henry Stanhope Bunting, DO, MD, contacted Still's son-in-law, George M. Laughlin, DO, to have Laughlin interview Still about Still's medical education.[1(p32)] This written account cited by Dr Gevitz represents Bunting reporting Laughlin reporting that Still attended the Kansas City College of Physicians and Surgeons (KCCPS).[7] In the second tertiary account, Grant Hildreth's book, published in 1938, relays an undated letter written by George Mahan, a prosecuting attorney in a case against Still. The trial, which Mahan recounts probably occurred between 1880 and 1886 when Still worked in Hannibal, Missouri,[5(pp115,117,129)] also represents a time span of about 40 years from the time of the event to the recording of the event. In Mahan's personal recollection of Still's defense, he fails to mention Still's medical school by name, stating only that it was a "southern school."[8(pp11-12)]

If Mahan could not recall the name of the school, are we to believe that he accurately remembered when and how Still "lost his diploma"?[8(p12)] Furthermore, can Dr Gevitz correctly conclude that it was Still who "changed the story"[1(p32)] rather than concede that Laughlin, Bunting, Hildreth, or Mahan might have made an error in quoting Still or in recording the school's name or the years that Still attended?

Perhaps because of similarities in the medical school names, even Dr Gevitz seems to err when he rules out (or incorrectly names) "the Kansas City Medical College and the College of Physicians and Surgeons of Kansas City"[1(p32)] as opening in the late 1860s. He does not report on either the KCSPS (the school named in Blanche's transcript) or KCCPS (the school named by Bunting), though one can surmise from the date of the KCCPS catalog that it likely opened its doors in 1868.[9]

All this banter does not negate the fact that the dates and location of Still's medical school attendance are uncertain. But does the blame for this uncertainty rest solely with Still? Nowadays, the memory of a graduation date is commonly aided by photos and a framed diploma. Perhaps Still did not have such records of his graduation.

Dr Gevitz is attempting to lay down the historical record, and he is to be congratulated for that. Recording the history of the osteopathic profession is an important task, but it could lead to potential

problems that were identified by Bunting more than 100 years ago when he cautioned that "some quibbling M.D. historian is very certain to try to pervert the truth in the years to come when records cannot perhaps be dug up."[7] The record might be better served by presenting it with a more neutral voice, by making allowances for alternative explanations, and by giving additional consideration to distinguishing a fact from varying degrees of probability. (doi:10.7556/jaoa.2014.125)

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Bosnian Refugees: Screening and Treatment in an Immigrant Population

To the Editor:

A large number of Bosnian refugees immigrated to the United States during the Bosnian War (1992-1995), with little money and little time to assimilate into a new culture and become fluent in English. It important for primary care physicians to understand the medical, emotional, and financial hardships confronted by the Bosnian community and to increase health literacy in this population.

Bosnian refugees are 3 times more likely to smoke tobacco than US-born residents, and the prevalence of Bosnian refugee smokers in the United States far surpasses the population of smokers per capita in Bosnia.[1] It may be that the hardship of moving to a new country with little financial or emotional support increases the rate of habitual use of tobacco. Many Bosnian immigrants also have psychiatric disorders, such as posttraumatic stress disorder and depression, even if they did not fight in the war.[2] Mental illness has a primary correlation with increased rates of tobacco use and therefore must be considered paramount when assessing these patients.[1]

A study of 499 Bosnian refugees living in St Louis, Missouri, found that 66.4% were smokers, 20.2% were nonsmokers, and 13% were former smokers.[1] Of the two-thirds of refugees who smoke, over three-fourths smoked more than 1 pack of cigarettes per day, which is a statistically significant higher pack use than that of the average smoker in the United States.[1] Bosnian American refugees understand that smoking is attributed to health problems and a shorter life expectancy; yet, they believe that their risk for tobacco-related illness is lower than that of other populations.[1] Further research must be done to understand the rationale behind this belief so that physicians can educate patients effectively.

Another factor associated with the rate of smoking in this population is cultural peer pressure. While 69% of US-born smokers want to quit smoking,[3] only 57.2% of Bosnian Americans stated they "really want to stop smoking."[1] The rest were ambivalent or did not want to quit because of cultural norms and the addictive nature of nicotine. Many refugees also associated smoking with camaraderie, and they believed that by quitting smoking they would lose valuable friendships.[4] Taking into account the perceived barriers Bosnian refugees face when attempting to quit smoking may guide physicians in educating this population.

Mammography screening is another aspect of Bosnian American health care that requires attention because many Bosnian women do not understand its importance.[5] Whereas breast cancer is the second leading cause of death in women in the United States,[6] it is the most common malignant disease in Bosnian women.[7] In a study of 91 Serbo-Croatian–speaking women between the ages of 40 and 79 years, only 44% had received a mammogram, whereas 65% of US-born women had undergone screening during the same period.[5] With the help of a female Serbo-Croatian patient navigator who conducted telephone calls, home visits, and educational group meetings, screening increased from 44% to 67% within 1 year.[5] That outcome reiterates the importance of understanding the language and customs of the population and indicates the possible

benefits of using a patient navigator who is familiar with the Bosnian and US health care systems.

As previously stated, Bosnians also face mental health problems, in part brought on by wartime and being forced to leave their homes and adjust to a new language and culture. A small study was conducted to assess the mental health of female Bosnian refugees who had not adjusted to the United States as being their "home."[8] The women were asked to describe their experiences of living in the United States, a question that elicited an abundance of past memories and present struggles. These women led relatively normal lives until they and their families were forced to leave Bosnia out of fear for their safety during the war. Once in the United States, many struggled, which further engrained feelings of inadequacy. The jobs that were available were in manual labor or factory work, with long hours and little pay to support their families. Some coped with their feelings by working excessive hours, while others took to dreaming and clinging to memories of the lives they left behind. When approaching a Bosnian patient, one must take all of these psychological issues into consideration and work to recognize how these experiences have shaped their perception of health care.

Although many Bosnian Americans speak some English, it is vital to ensure that patients comprehend health care information to make decisions and follow instructions for treatment. Guidelines should be established to assist providers in effective communication methods with this population. Children in the family often serve as interpreters; however, this communication is not effective because a child may not grasp the complexity of medical information given to them. Instead, providers should use patient navigators, experienced interpreters, and translated pamphlets to effectively deliver information. Language Line, which allows health care providers to speak to interpreters throughout the world, is an option if other means are inaccessible.

Physicians might encourage patients, especially those who feel isolated from the community, to engage in social activities or groups. Bosnian community events that appeal to all ages are an effective way to educate the population. In the past, programs such as Coffee and Family Education and Support for Bosnian Families (CAFES) were established to bring families together for discussions.[9] These organizations focus on creating a supportive social environment where families can interact, teach, and learn from one another.[9] A similar approach may be beneficial when addressing smoking cessation, mammography screening, and mental health. (doi:10.7556/jaoa.2014.126)

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Correction

The *JAOA* regrets an error that appeared in the following article:

Lamberg JJ, Adhikary SD, McFadden AT. Osteopathic musculoskeletal examination and subarachnoid anesthetic administration in a patient with severe stenosis. *J Am Osteopath Assoc*. 2014;114(7):582-585. doi:10.7556/jaoa.2014.112.

Mr Adhikary's degree was published as "MB." It should have appeared as "MBBS." This correction will be made to the article online.