Questions and Answers with Anne Flitcraft, MD

Why and how did you get involved in responding to and preventing gender-based violence?

Medicine was my career goal long before college. Like many others in my 1960's cohort, I worked on voter registration drives, anti-Ku Klux Klan rallies in Indiana, and AmericaCorpsVISTA work in Cleveland in the summer of 1968. That fall, I transferred from a traditional college to Earlham College, which had many activists. I left college altogether in 1970, moving to Philadelphia to do anti-war work with the American Friends Service Committee. These were also the early days of the women's movement, and confronting sexism became part of our personal and political lives. So, when I arrived at Yale Medical School in 1973, I was already an activist committed to social change. My nascent feminism was honed during my pre-clinical years when I encountered anti-female jokes in anatomy lab, the tacitly-sexist humor of embryology lectures, and the general challenge of being an unwelcome gender minority in an old boy's institution. Medicine could play a vital role in facilitating social justice by enhancing equity and general well-being. But to do so, fundamental changes were needed in the research knowledge base, the curriculum and professional training, as well as in clinical practice, health care organization, and access.

In late summer of 1975, on the way back to Connecticut from a clinical rotation in San Diego, my husband and I stopped in St. Paul, MN to visit an old friend, Sharon Vaughn. We located Sharon in the attic of a large home, writing grants while women and children engaged in a range of activities that filled the living spaces below. She told us the story of how she and other members of the organization, Women's Advocates, largely supported by donations from women in thecommunity, had opened Woman House a few years earlier. It was the first US shelter for victims of partner abuse. I was finished my pre-clinical lectures, but "battered women," "spouse abuse," and "domestic violence" were news to me. Judging by the enormous demand for space at Woman House, these issues were a huge problem. I scoured the medical literature for information about domestic violence and only found four relevant articles: three in British medical journals and a single 1964 article from the (American) Archives of General Psychiatry. That fall, we attended a conference to discuss domestic violence held by social work students at our local YWCA. Over the next few months, about a dozen of us who had met at the YWCA meeting started the New Haven Project for Battered Women. We opened our home as a "safe house," began the hard work of educating the community about the problem, and started securing funding for a shelter.

The more I learned about domestic violence, the more perplexed I became. I did not understand how such a prevalent a problem that had obvious significance for women's injuries and health, could be virtually invisible to medicine.

What are some challenges and success you've experienced along the way? Research challenge and success:

Incredulity has been a challenge at every stage of the early work. The fall of 1975 brought an opportunity to research domestic violence to fulfill Yale Medical School's thesis requirement. I approached William Frazier, MD, Director of Emergency Medicine at Yale, with a request that he sponsor my research on "battered women." He was delighted to do so, advising me that there was a rich trove of data that needed evaluation from the recently established rape crisis team. "No," I corrected him, "not rape, battered women." He replied, "What's a battered woman?" When I told him about my literature review and the growing shelter movement, he handed me access to emergency room records, a work place, a statistician and an expense account at the Yale Computer Center; unheard of riches for a medical student of the day.

The next challenge was devising a method to identify battered women in the medical caseload. How could one determine the number women entering the health system with injuries sustained from partners if there were cultural, gendered taboos, scientific "gag" orders, and linguistic hitches that made partner perpetrators irrelevant and invisible as sources of injury, and assumed adult injuries were accidental unless they were muggings? My point of entry was the "index of suspicion" Henry Kempe had developed in his 1962 work on child abuse. Another core assumption reflected the growing political understanding of women's health. What would we find if we assumed that *all* injuries to women had a social origin unless otherwise proven? To use the jargon of the time, this meant interrogating medicine from a standpoint other than its own, and acknowledging that:

> "Patients triage themselves to the emergency room and despite the complaints of staff; it is, in the end, the community which defines the needs a medical facility must meet. However, this definition is not always immediately apparent for it is hidden within the complex categories of medicine which mystify social collectivity. This research is an experiment in reconstructing that collectivity from the individuated histories of women seeking aid." (From Anne Flitcraft's thesis, 1977)

The first public presentation of my research findings was, appropriately, at the US Civil Rights Commission hearings in January of 1978. My one-month sample for the thesis was followed by a much larger research project. I conducted the larger project between 1979-1984 with support from the National Institute of Mental Health (NIMH), which enabled me to establish a research team, use much larger and more diverse samples, and apply more sophisticated statistical methods. The project that we now call "The Yale Trauma Studies," validated and refined my earlier work, demonstrating how abuse contributed to a range of women's medical, behavioral, and psychosocial problems. The reactions to some of the findings (e.g., that domestic violence is the leading cause of injury for which women seek medical attention) initially ranged from denial to skepticism. Fortunately however, our conclusions are well within the ballpark of subsequent work based on interviews and more sophisticated methodologies.

Researchers have greatly expanded on our conclusions that substance abuse, poor pregnancy outcomes, women's mental illness, and child abuse are often rooted in partner abuse. Later, findings linking violence against women to women's health problems were vital in reaching physicians in medical and surgical sub-specialties in the following years. I worried, however, that research was turning inwards. While research on domestic violence and health proliferated, it seemed like the same questions were being asked repeatedly and the conclusions drawn were already well known in policy circles and to the advocacy community. The challenge was to return to the goal that had motivated this work in the first place: societal change, and change in medical education, professional training, and clinical practice.

<u>Training challenge and success:</u>

With a strong knowledge base at our back, it seemed time to engage with the medical community directly, even if this meant short-circuiting our very supportive NIMH funders, who had a 10-year timeline of research before engaging in training and program development. In 1986, as part of Connecticut's Family Violence Prevention and Response Act, the state provided funding through the Connecticut School of Medicine for The Domestic Violence Training Project (DVTP), which I directed. Initially designed to assist hospitals in introducing protocols to identify domestic violence victims, DVTP secured funding over the next 15 years from the March of Dimes, the Commonwealth Fund, the State of Connecticut, and other sources. The funding was used to train a wide range of health, social service, and justice professionals locally and nationally; to develop model programs with the state's community health centers and the Connecticut Medical Society; and to work with national medical and public health organizations to develop practice guidelines for their members.

One highlight of the DVTP was our participation in an unprecedented workshop on "Violence as a Public Health Problem." C. Everett Koop, US Surgeon General, and Marc Rosenberg, MD, director of a new Division of Deliberate Injury at the CDC convened the meeting in the fall of 1985. In addition to highlighting spouse abuse, the workshop produced a range of recommendations for prevention and intervention that were critical to shaping medicine's response to abuse, nursing, and public health over the next two decades. The workshop was followed by first National Nursing Conference on Violence Against Women, and then by regional conferences that included local representatives from the same range of organizations that had first convened in Washington. These developments satisfied an important goal I had set for DVTP—namely, to put domestic violence on the national health agenda.

Posed with the choice of devoting myself to training full-time or maintaining my teaching and clinical responsibilities at the Burgdorf Health Center in Hartford, I decided to return to an earlier challenge and help physicians become aware of why an appreciation of violence was crucial to overall patient care. I termed this awareness "clinical violence intervention." Understanding violence was about more than identifying battered women in your practice. Physicians needed to appreciate the realities of abuse or the threat of abuse, and how it touched every aspect of women's health and health-seeking. It seemed impossible to care for a patient without asking and understanding their experience of violence. With rare exceptions, physicians did not yet see violence against women as a problem that directly affected patient care.

In 1990, staffers from the American Medical Association (AMA) raised the issue of spouse abuse, and the following year the AMA announced its campaign to prevent family violence. With staff support, in 1995, a committee of physicians produced the guide, "Diagnostic and Treatment Guidelines on Domestic Violence." (A similar process later led to guides on child abuse, elder abuse, and sexual assault). These guides formed a critical bridge between a general, public health awareness of abuse and addressing the problem in private and specialty practice. With the endorsement of the AMA, state medical societies and sub-specialty groups initiated widespread educational programs to reach practicing physicians and dentists in nearly all sub-specialties.

What do you consider the most important aspect of your work/advocacy

Of course, the most important result of our research, training, and advocacy was to put domestic violence on the national and even the international health agenda. What began as a visit to a shelter in St. Paul, was extended, through a medical school thesis, into a major research program. The program evolved into opportunities to affect every aspect of health care, and it has culminated in a widespread understanding that domestic violence is a major contributor to women's health. Of course, my achievements during this process were inconceivable, except in the larger context of a worldwide battered women's movement that made it impossible to continue to ignore the role of injustice and sexual inequality in women's personal lives. I was one of dozens of researcher/advocates in medicine, nursing, public health, and social work who defined violence as a public health issue.

I would also have to rank changing medical curriculum as a major success, particularly as a result of the Association of American Medical Colleges (AAMC) pre-meetings in mid-1994 and AAMC's subsequent inaugural conference educating medical students in issues of family violence. Mandated as a condition of accreditation by the AAMC, the integration of violence into the medical school curriculum set up the first national conversation about what knowledge, skills, and attitudes were needed to accompany medical education on domestic violence. The knowledge base was wide and fairly specific; it ranged from epidemiology to law and local resources. Gaining this knowledge in itself did little to change the traditional hierarchy of medical practice. However, teaching the clinical skills to address interpersonal violence shifted the power in doctor-

patient relationships towards greater equality, created respect for patient autonomy, recognized the importance of patient knowledge, and acknowledged that inequality has significant health consequences—particularly when it is enforced through violence and control.

With the AAMC initiative, ever so slowly, education about domestic violence in medical schools is reinforced by more recent emphasis upon patient empowerment and the general re-thinking of the "doctor knows best" kind of medicine that existed when I entered medical school in 1973. I am happy that our work may have contributed to global change in how medicine thinks about women. But, I am most gratified that my work may have helped change how we think about and engage power in clinical care, as well as the inequality imposed on women in clinical settings, medical schools, and health care organizations.

What would a violence-free world look like to you?

I think I would have to read a lot more poetry to answer that question. But one lesson I've learned from my patients is that abuse is not just about what men do *to* women. It is, perhaps first and foremost, about what men keep women from doing for themselves. Violence cannot end without ending the types of inequality and injustice that plague our societies.

How can others get involved in preventing gender-based violence

We used to joke that once you see the world through the lens of domestic violence, nothing will ever look the same. So, dare to look at the world through this lens. Re-examine what you see, and a myriad of opportunities will suddenly appear.