

Dr. Anne Flitcraft Oral History Interview

CJ: This is an oral history interview with Dr. Anne Flitcraft, physician pioneer of medical reform to improve the treatment of survivors of domestic violence. We're going to be talking today about the medical identification, treatment, and prevention of domestic violence in the 1970s, '80s, and beyond. I'm Catherine Jacquet, a historian and post-doctoral fellow at Macalester College. The day is March 3, 2014, and this is a phone interview. So, Anne, thank you so much for, for talking with me today. I appreciate it.

AF: My pleasure.

CJ: And so, I thought we could start with the basics to get a sense, you know, the basics like, when and where you were born, and where you grew up, and from there, I'm curious about your path into medicine. So...

AF: (Laughs) I was born and raised in St. Louis, Missouri. My mom was a nurse, briefly, until she had four children, and my dad was a chemical engineer who worked in all kinds of, worked with early computers, worked with, ended up doing a lot of business administrative work with Monsanto. He's still alive. He's 93 and he's working on developing a museum of, of the work that was done largely through NASA and how chemical engineers were involved in, sort of things on beyond. (Laughs) And, I think I always, that, so that's sort of where science came from in my life, is both from my mom and my dad. And, I guess I always, I grew up assuming I would go to college. In those days, you sent girls to college just in case something happened, which meant, if you lost your husband, then you would be able to get a job. That was why you sent girls to college. But my folks were actually very good and, and gave me chemistry sets and divisible man, and learned very quickly that I didn't take to Barbie Dolls and sort of supported that part of things. And I did a lot of sciences in high school, weekend science programs and so forth. So they were very supportive about that. And went away, went away to college in 1966. I went away fully anticipating that I would do a pre-med major. But this was 1966. And there was a lot going on in 1966. I was in Indiana, and believe it or not, there were voter registration drives going on in 1966. And, of course...

CJ: Were you at the University of Indiana?

AF: No, I was at DePauw University in Green Castle, Indiana.

CJ: Oh, DePauw, yeah, okay, yep. Okay.

AF: Yeah. And, so I was there for two years, but by then things were really getting politically... Most young people that I knew were involved politically at that point. And, one of the issues of the time was the Poor People's Campaign. And Earlham College was the center of the Poor People's Campaign so I transferred to Earlham and became like a philosophy major, or some such thing. But, certainly wasn't going to keep pre-med going, and continued then to do domestic political work and also anti-war work. And then in the spring of '70, the U.S. invaded Cambodia. I think, it was the invasion of Cambodia, the bombing of Cambodia, whatever. A big event in the war, and I dropped out in the middle of my senior year. At that point I had, at that point I had, I had moved from being a pre-med major to a philosophy major, to an art major. And my area of specialty in art was basket weaving. And I did have the sense at the time that I probably didn't want a degree in basket weaving, largely because I had no talent. There were people in my program who had a great deal of talent, and my sister's an artist, graduated from Earlham and had a spectacular career as a ceramic artist. But, I had no talent, so this differentiated me from her. So I left and started working with the Friends Service Committee on their anti-war work, and continued to do anti-war work through the end, end of the war. But meanwhile, went back to pre-med at night school at the University of Pennsylvania.

CJ: And what motivated you to do that?

AF: Well because I knew the war was going to end, and then what was I going to be? I, I was an untalented basket weaver, so... (Laughs). Yeah. But, I mean, all of this had to do with providing, providing

medical services to the disenfranchised populations that I'd been working with, you know, through the Poor People's Campaign and so forth. So, so medicine and politics sort of got melded very nicely together during those years of moving in and out of those two kinds of things. And so after two years, I was able to get my degree in biology from the University of Pennsylvania, and ended up at Yale Medical School. Now, why Yale Medical School? Because, Yale was opening up its doors to women at about that time. And, well it, it had opened its doors to undergraduate women a few years before. But, the graduate schools were opening their doors to women. So, there was a, there were more women in my, there were ten women in my class. Compared to like the two the year before, so...

CJ: So right, and what year did you start Medical School at this point?

AF: I started school in 1973. The fall of '73.---And basic, I mean other, and, and sort of the thing that got added in, in those years was the emerging --women's, the women's movement. And, the conscientiousness raising groups and so forth and so on. And so, I sort of moved throughout that whole political spectrum and then got involved, peripherally really, in the women's movement in New Haven. Since I was a medical student, it was sort of hard to be, it was at least for me, to do much more than that. But I was involved in the early conscientiousness raising groups. And I think that probably, all those things put together sort of gets me to how did I get involved in violence against women? Because the issue at the time in the 1970's in the United States was the rape crisis movement. And the emergency services and so forth. Women, the women's movement was putting a great deal of pressure on both, on police to do better prosecuting and also on hospitals to begin providing more sensitive care for women who'd been sexually assaulted and also to work more directly with the police to put together evidence that would hold up in court. So there was this model of kind of women in violence and health, but it wasn't called "Women in Violence," it was, it was like "Rape and Health." And there was no consciousness about abusive personal relationships. And interestingly enough, in spite of consciousness raising groups across the country involving millions of women, the issue of violence in our inner-personal relationships wasn't on the agenda.

CJ: Well, and it, it starts on the agenda in the mid-1970's right, when you get the emergence of the battered women's movement?

AF: That's (Inaudible), but that's...

CJ: A little, a little later on.

AF: A little, well let's see--because Evan and I were involved in starting--and it must have been '74, '75, yeah. So, it wasn't in the early days that the shelter movements were started. They were not initially started by--well--with one notable exception, which was the first. Sharon, Sharon Vaughn is a...

CJ: Yeah.

AF: Do you know her?

CJ: Up here in Minneapolis, right?

AF: Yeah, in Minneapolis.

CJ: I don't know her, but yeah, yeah, I know (Inaudible).

AF: And Sharon certainly is a--she's, she's, she's a feminist with a capital F, and a little f, and a...hyphenated f, and...(Laughs) She, she, she is. And actually, it was two years into medical--and, and we had known Sharon from anti-war work in Minneapolis. And when, and we were in--when I say, "we," I mean Evan Stark and I--were in California, I guess it was the second year, the second summer of medical school. So that means, so that would summer of '75, and we drove back east and stopped to see Sharon on the way. And, Sharon was upstairs in the attic writing grants and the house was overflowing with women and children. And Sharon, what were you doing? Well, she'd been running a legal services hotline

and they were really able to answer most of the problems. Except if you weren't safe at home. And so if you weren't safe at home in Minneapolis, you went to Sharon's house. (Laughs) Or one of the various safe houses that was, that was, you know, the, the, the precursor to the shelter movement.

CJ: Right, okay.

AF: And in the wake of that experience with Sharon, we came back and I started work. I had to do a research project to graduate from medical school and everybody was kind of, at this point, expected to be outlining their research projects. And what you really were supposed to do was to figure out what sub-specialty you wanted to go in, and then you were supposed to find a professor who was doing research, and you were supposed to, you know, hook on to that professor and get mentored. And, yeah, that's what you were supposed to, like help a professor. And, I was, I was like, I didn't know anything about medical school, right. I thought, you know, you, you studied, you did the, whatever. I didn't know anything about the culture of medical school, and I thought when he said, you do a research project, you did a research project. So, I looked to see what was known about violence against women. It was all rape. Battered women, there was one article in the, in the, in the British, in the Lancet. Which was an article on the injuries, a catalog of injuries that had been sustained by women who were in a shelter in England, to see, see in the U.K., and we later went to the U.K. and they wanted to know all about the rape crisis unit because, in the U.K., they got involved in domestic violence while we were getting involved in rape crisis. So, at any rate. So, there was no medical, real, there was no U.S. medical literature. There's one ER, it was a report by a guy named Warren Appleton about a year later in the Annals of Emergency Medicine. And I don't know what happen to Warren, because he wasn't later involved in the movement, but, at any rate. So, so my initial research was sponsored by a guy named William Fraser who was a, he was a director of the ER at Yale-New Haven in the '70s. He was a plastic surgeon whose mother was on the YMCA board, the YWCA board. And the Y...And the Y's were getting involved in the early shelter movement. So, I think part, I mean, I, I think he was influenced by his mother to take me on (Laughs)...And resources and so forth. I mean this is something his mother would like, right?

CJ: Right.

AF: And, so he was very generous in giving me space to work and so forth. But, when I went to him and I said I want to do a, and the, the only language I had was "battered women." Now, we've come miles and miles and miles from that, but. That was the language I had. I said I wanted to do a, a research project on battered women. And he said, oh that's wonderful because Barbara Moynihan, whose a nurse has, has been working with the rape crisis team for now several years, and we haven't had a chance to pull together that data. And I said, no. I don't want to work on rape, I want to work on battered women. And he said, "what's a battered woman?" So that really started if off. And we, and, and, and on a whim, you know, he had all the Xerox pages from--not, you know, then it was triplicate carbon copies. So he had all the pink sheet, sheets, which were the third carbons from the emergency room visits, and it was his job to review all of them as Director of the ER. And so I, so I said, well do you have any pink sheets? He said, well yeah, his last man's pink sheets. So, I said, well you got some time, let's divide it up and see. So we divided it up into men and women. And we went through and, it didn't take long before--because he, he, they were all people who'd come in with injuries. It was not the medical side of the ER. And it wasn't long before, sort of, it was obvious to both of us that something was going on. That there were, that there were injuries that you just wouldn't expect and...

CJ: And injuries on, on women patients, right?

AF: Yes.

CJ: The stuff like that you were, you were putting the pieces together about...

AF: Right.

CJ: Or answering the question, what's a battered woman?

CJ: What's a battered woman? Right, right.

AF: Right, right.

CJ: And there were, you know, and there were, there were women, you know, who'd been beat up and there were women who had been brought in by police and, you know, who had been beaten up, or had been assaulted, on a, at the mall. And there's clearly a different language that was used to describe these people.

AF: Or the, you know, women who'd been, who, who'd been slashed with a knife. You know, so, it... So even the language carried some assault, as opposed to, you know, cut while, you know, cut finger on vegetable knife, or something. You know, there, there was a different language that was used. So clearly there was a, there was something different going on in these cases. And so what, what I ended up doing was, and it was also very clear that you couldn't get much from one ER visit. And if your question was, what's a battered woman? You're not going to really get it from one ER visit. So the methodology that I developed was that I would take an entire month of ER records, women's ER records, women who came with injuries. And I would get their entire medical record, which was all of their emergency room visits, all of their clinic visits to Yale-New Haven clinics, all their hospitalizations and so forth, and so on. Obviously there was a lot of holes. Maybe they went to other hospitals and, you know, people criticized the early research for all of that, but that would have only made the early research even stronger. But anyway...So, so, you, you take this group of 400 odd women and you get all of their medical records and you start looking, initially, for every emergency room injury in that record. And you look at the record, and you say, oh it says, she was beat up by her boyfriend. Well that's a positive. That's pretty clear, right? And then there's the one where she was, where she was, hit with a fist. Well probably if you were, if you were assaulted, like someone you didn't know, you wouldn't go to, you wouldn't say you were hit by a fist. You know, somebody would break into your house and beat you up. Or somebody would, you know, try and snatch your purse, you know, there would be (Inaudible).

CJ: There'd be more of a story, right?

AF: Yeah. Right, right.

CJ: Yeah.

AF: Right. So, we actually called those "probables." And then, there were things that were suggestive, like walked into a door and got two black eyes. So the story didn't add up. And then, there was, you know, comes in at 6 o'clock, at 7 o'clock at night with a cut across her thumb, having been chopping vegetables, and that was a negative. And so, quite independent of the women, we took these, almost 3,000 injury episodes, and independently catalogued each injury episode into one of those groups. And then we went back and we said, okay. Then we re-aggregated them into their respective medical records, and said, okay, this person has at least one positive episode in their chart, so we're going to call that a battered woman, a positive. This one has a, at, a probable episode, but no positives. So, those are going to be our probables. This one has suggestives, but no probables or positives. So, those are going to be suggestive of battered women. And then these have nothing but negatives, so they're going to be, not battered women. Some of this, some of this kind of thinking was based on reading Henry Kempe's early child abuse work from the 1950s. And the model of how medicine sees but doesn't see...is drawn straight from Kempe. So, theoretically, the work owes a, a tremendous debt, in, you know...

CJ: To Kempe?

AF: To Kempe, yes. It doesn't theoretically owe a debt, it owes a huge debt to the theory (Laughs) in terms of developing the methodology. You know, and so, so then at that point we had, and, and, you know, then you had to have--and this is where Bill's, Bill Fraser's support was so important. Not only did he assign a couple of nurses to help me with some of the secondary abstraction of the medical records, but he also provided funds for analyzing the data. Which at, which at that point was on punch cards. You don't know even know what a punch card is.

CJ: Oh, right, right. (Laughs)

AF: (Laughs) Do you know punch cards? And you had, you took your boxes and boxes of punch cards over to the Yale computer center. And somebody climbed up on a ladder and put your punch cards in at the top, you know.

CJ & AF: (Laughs)

CJ: Incredible.

AF: Amazing, right.

CJ: Incredible, yeah.

AF: But, and it turned out, and it turned out, that it was, it was, it just, it was, it was amazing. It turned out that the people who had, the women who had a positive episode in their medical record had, on, had the highest average number of injury episodes in, as a group, they had the highest number of injury episodes. They would come in...

CJ: Which makes sense, right? Because she, they're part of, they're in a cycle of violence (Inaudible), right?

AF: If you believe that there is something called a battered woman, it does make sense. You know, you have to sort of, you know, run, run backwards now 40 years, and realize that there was no description of a battered woman. To, to realize that it, it's just sort of like the ah-ha-moment of this. And, and I think the average number was--I, I don't know--eight or ten. A lot of injury episodes.

CJ: Of injury episodes per woman, yeah.

AF: Yeah, yeah, and the, and the probables, like, and, and the injury episodes that aggregated in the positive charts, were positive probables and suggestives.

CJ: Right, right, of course. Now were you just completely, like, like, when you found this, did you have the ah-ha-moment, or what was the experience of, you know, putting this data together?

AF: Oh, I was tremendously excited. It was tremendously exciting. I mean, you know, it was, it was better than having your chemistry experiment come out exactly as it's supposed to, I mean. (Laughs) It was, it was mind boggling. That this simple idea actually worked. And, and that in fact you could divide this, this group into these, and that the average number of trauma visits decreased, you know, per woman as you went from positives down to negatives. And, and basically, the, it... If you'd been in the emergency room more than three times with trauma... There was an 80% chance you were in an abusive relationship. You didn't have to ask questions, you didn't have to do fancy algorithms, you know, all and all, this world's worth of stuff on risk factors, and so--this is a, "have you been here before with injuries"? Or you just had to look at the record. And so, from that came what I came to call the adult trauma history, which...Which in, you know, yeah it was exciting to discover that domestic violence is represented in the medical record and that healthcare is an incredible resource that women in violent relationships turn to. And they don't just come for knife wounds and gunshot wounds, they come for a variety of injuries that you and I might not go to the emergency room for at all. We might just put a piece of ice on our head. But, you know, where are you going to be safe? In an urban emergency room, there's a pot of coffee, there's a security guard, and unless you've got, unless you're bleeding, you're going to be there for a very long time. So it, so the more we got involved, the more it made sense that, that women were using emergency rooms in all kinds of ways, and that emergency rooms were really important. Understanding this and demonstrating that this population existed and that they told people that the, that, you know, some of the positives were from the doctors' writing. Some of the positives were from the nurse writing. Some of the positives were from the x-ray technician. So, it wasn't difficult to get this "admission" from women, which was in, and, but, so that

was, that was the first part of research. The second part of it was, well, since we had their whole medical records, what else happened in their medical records? And that's where we began to link the experience of abuse with a, a broad range of health problems. Some of them directly related to abuse, like deafness or early onset of arthritis, or neck pains from, you know, being held about the neck and having your, you know, head banged up against the wall, or concussions. Symptoms of concussions with prolonged headaches and so forth, intractable sinus infections because your bones were broken and the, and the normal sinus anatomy was disrupted. And, so, you know, as well as things, things like depression and suicide attempts, and...Very, very late in the onset, after lots and lots of injuries, you begin to see alcohol, drug abuse, suicide attempts, which was interesting. Because one of the few places that you saw domestic violence discussed, was when a woman who was a known alcoholic came in all beaten up. Then she was an alcoholic beaten up by her boyfriend. Well, now we had an explanation. She was an alcoholic. Yeah, so that was the primary issue which then led to the, right? I mean that was the interpretation. The primary issue is the alcoholism that leads to the beating, but not vice versa. Well that was... Yes, that's how medicine could understand it. If she's an alcoholic, yeah, I'd beat her up, too. I mean. As terrible as that sounds, that was kind of what the linguistic history looked like.

CJ: Yeah. Yeah, absolutely. So you all are beginning to challenge that with this research in a really significant way?

AF: Absolutely. Absolutely. And, and, and about that time...about--I guess, so I finished in '77. So it must have been in '76, Connecticut had--and we were also by this time... Our house was a safe house and we were starting to work with a group of men and women from the welfare department, social services, a local church. We did a conference at the Y. So they were starting--but again no feminists, interesting. Not the women's movement.

CJ: Fascinating.

AF: It's so, it really is interesting. [Laughing] And, and many probably would challenge me on that. You know, I think the nurses who were involved, I think were more involved in the feminist movement. But certainly not...Not, not on the ground and not in medicine. But at any rate, there were a series of speak-outs about, about... Was it rape? I think it was about rape, but it might have been about domestic violence. In, you know these telephone call-in things? When you don't identify yourself, but you just... And--so, it must have been in like '78 that the Connecticut legislature wanted hearings on this issue. And somehow this, my research came up and so my research was presented then.

CJ: Great.

AF: And, and then there were hearings down in Washington at the Civil Rights Commission and, again, I presented my research, but, you know, I'm sitting here thinking, man this is like medical student stuff. You can't really, you shouldn't like, have federal policy based on medical student stuff. And, so instead of going to a, instead of going to a traditional training program in... Yeah, here it is, the hearings before the Subcommittee on Domestic and International Scientific Planning Analysis and Cooperation. Of the Committee on Science and Technology, the U.S. House of Representatives, February 1978. Research into violent behavior, domestic violence. And the only...

CJ: And that's where you presented your research?

AF: Yep. Yep. And it's the only medical research that was presented.

CJ: I was going to, that was my next question, yeah. Because it seems like this research, like it--I know that other people start doing research. But it seems like yours is really the first research that we see, I mean, nationally even, that's taking on this issue, in terms of like medical research.

AF: Yeah, the other people were, the other physician, Eli Newberger was head of the child abuse program in Boston. So, he presented.

CJ: Oh, was he working with Susan Schechter?

AF: Susan Shechter's program... Susan was probably still in junior high school at this point. (Laughs)

CJ: Oh yeah. Oh, yeah, because this in the '80s, her Awake program.

AF: This is '78, this is '78.

CJ: That's, oh that's right. Yeah. Her, yeah, her Awake program is in the mid-'80s or late-'80s or something, yeah, yeah.

AF: Yeah. Yeah, I think she's still getting her degree.

CJ: Okay. Oh yeah, oh yeah, okay.

AF: And now the hearings... Yeah. The only, the only--no so Eli, and a couple of other pediatricians, spoke. Must be physiatrist, Toby Myers, from mental health services; and then Susan Steinman, in sociology; Lenore Walker, psychologist.

CJ: Oh yeah, Lenore Walker, she's the battered woman syndrome.

AF: Yeah, right, right. She spoke (Inaudible). But, and Strauss spoke, and Saleem Shaw from the Centers of, from, from HEW, and Tom Lalley. Now the, the reason those two names are important is because, you know, I was presenting, yeah, Ann Flitcraft, post-doctoral fellow. (Laughs)

CJ: Oh, right.

AF: Right, so, I--because I didn't do an internship right away. I went in to a post-doctoral fellowship at Yale, and during that year, wrote, along with Evan, a much larger grant that was methodologically much tighter. With a, with a, with a, you know, real research group, and a budget for data analysis, and so forth. And that, that was funded by, this is interesting, Tom Lalley. And Tom...

CJ: How do you spell the, how do you spell Lowry?

AF: It's, no Lalley, L-A-L-L-E-Y.

CJ: Oh, Lalley. Okay, got it.

AF: Tom Lalley. And he was a deputy chief at then, Health Education and Welfare, H E W. And his buddy at this talk was Saleem Shaw, S-A-L-E-E-M S-H-A-W. And he was at the Centers for the Study of Crime and Delinquency at the National Institute of Mental Health. So he worked with Tom Lalley. Tom Lalley was the overall director and Saleem Shaw was the director of the Centers for Crime and Delinquency. And when we submitted our grant to the National Institute of Health, of Mental Health, the research grant, it was Saleem Shaw who then came to New Haven to do the site review. And it was Tom Lalley who for years was the person that we would stay in touch with in Washington...about the findings and so forth and so on. I had not realized until just now when I pulled this out that, in fact, Shaw and Lalley were the lead-off speakers for these hearings. That's interesting. That's interesting. Yeah.

CJ: Interesting. Yeah. Yep. So not a surprise that they funded your research, then. I mean they're so, right (Inaudible)?

AF: Well, it's interesting, you, I wonder whether or not that's where they sort of heard of it. Because I spoke a half a page later. So, so that was, that was actually probably a very fortuitous hearing.

CJ: Yeah, it sounds like it.

AF: Because since there was no medical literature on battered women, it would, it's very difficult to get a research program started. That's one of the catch 22's, and that's...

CJ: Right, because you don't have the literature. Yeah.

AF: Yeah.

CJ: You don't have the literature to justify the need for the work, et cetera, et cetera.

AF: Right, right, exactly.

CJ: Because what you're doing is (Inaudible)...

AF: It's always, it's always easier to do somebody else's work again, than it is to do original work.
(Laughs)

CJ: Right, and break new ground and, I mean, because you're starting from the position where people don't even know what battered woman is, right?

AF: In healthcare they don't. (Inaudible)

CJ: In healthcare, right, right, right. And that was another question I had for you. You know, Dr. Fraser was supportive of your work and affirming of what ya'll were doing. Did you get a sense of other people's response to the work? Did you get people just not clear on what you were doing? Or, why? Or, you know, or did...

AF: Well, it turned out my thesis was circulated among the secretarial pool at the medical school.
(Laughs) The secretaries loved it. The secretaries loved it. The critical reviewer, you know, who had to pass on it, you know, to review all these things and pass on it to, to let you go ahead and graduate felt that the literature review was terribly thin.

CJ: Well, there's no literature on it.

CJ & AF: (Laughter)

CJ: He had to correct, right.

AF: So, you know, and, and, so, it was, it was an outlier then and when I... Oh, and the program that I applied to at Yale was a program on, it was a, it was a program run by mental health people, psychiatrists and psychologists, and so forth, and funded by the National Institute of Mental Health, it was on program evaluation, and one of the two guys, one of the guys was very supportive, but the other guy argued against my coming into the program because he said, well what does this have to do with mental health? It boggles me when I think about, and I was, I, you know...

CJ: I mean that was, that was the understanding at the time, right? Yeah.

AF: Yeah. Yeah, it was, it was no understanding, and therefore, understanding all, right? If you didn't understand anything. (Inaudible), then, of course it didn't have any mental health repercussions. But I, and, and a part of my being, trying to do the groundwork to get into this program--actually is, in a--was there was a, there was a guy, a psychology--no, was it?--psychiatry resident by the name of Bruce Rounsaville, who by this time was trying to do some work over at the Community Mental Health Center to identify battered women. And he said Anne, I'm having a terrible time, I can't find any battered women. I said Bruce, that's ridiculous, I can, I see them referred from the emergency room over there all the time. They got to be there. So I took a copy of Del Martin's book, "Battered Wives."

CJ: Yep.

AF: Okay, yep.

CJ: Yep. Got it.

AF: And it had just (Inaudible), it had a black and blue cover with--oh, it was awful. And I sat in the coffee shop at the Mental Health Center at the counter, and ordered a cup of coffee and just set this book at my side. And in the span of an afternoon had wonderful conversations with half of a dozen women who were-- can't say inmates, they were patients--at the Mental Health Center, who came over and said, oh, look at that, you want to hear my story?

CJ: That's incredible.

AF: So it was just like, so... It was, it was so easy then.

CJ: Wow, that's amazing.

AF: To, and then of course as soon as the shelters opened up, I mean, people told all kinds of things about... And we came to really understand abuse in all of its manifestations. And, and sort of, it, at, in you know, in working in the shelter movements and so forth. But, but doing the, doing the research grant, we were then able to explore more direct relationships between suicide attempts and child abuse and alcohol abuse, and, and basic, and, and provide more validation to the original...scheme of things. And it became clear in that, that because we had much better, we had much bigger budget to do data analysis that we, that, that the bulk of the medical care, that not only did battered women use a tremendous amount of emergency services, they use a tremendous amount of healthcare services. And, some of it was, some of it was directly related to abuse. Some of it was related to their safety strategies. Women who would stop, who, Elaine Hilberman, in Carolina, has a story of a patient of hers who's on seizure meds, and the only time the guy would let her out of the house, was when she had a seizure. So, when things were getting pretty intolerable, she would stop her seizure medicines. You know, and, and, it, you know, it just, the, the myriad layers of relationship to healthcare are, are just phenomenon. And, so the work allowed us to, to expand a lot more into those kinds of areas and increasingly to understand it in terms of what, what Evan has come to call coercive control. And, but, from our, from the, where we went with the research after... We told Tom, after about two research rounds, that we were, we were done. We really wanted to move to training. And he said, ah, you're not on the training track, yet. You have to do ten years of basic research before you do training. And we said, Tom, we can't do that. We can do that.

CJ: Yeah, we can't wait ten years.

AF: Life is short.

CJ: Seriously.

AF: Life is short. (Laughs)

CJ: And, and this is while you're on your post-doc, right?

AJ: No. Now--see I did my post-doc for a year.

CJ: Okay, oh, okay.

AF: We got the grant. And then I went into an internship.

CJ: Oh. That's right, that's right, okay.

AF: So I went into an internship and supervised the group from afar, and Evan was involved in it, too. So he was sort of the day-to-day. And then, and then, but it was interesting. When the work on suicide came

out, when, when that piece got worked out, and the, it was accepted for presentation at the American Public Health Association meetings, which are big meetings.

CJ: Oh great. Yeah.

AF: And my program director would not give me time off to present the work.

CJ: Why? Because was this director like hostile to your work?

AF: It didn't have anything to do with medicine. It didn't having anything to do with medicine. And, so I did a med-surge internship and then Evan got a Fulbright to England. And I was sort of waiting around hoping I would, that emergency medicine would open up, because I thought that was going to be primary care for the poor; how wrong I was, but at any rate. So, I left my clinical position. I, I withdrew from my second-year position, and went with Evan for a year to England.

CJ: Okay. And what year is this? Are we up to...

AF: That would be 19--let me see, let me see; that'd be 1980, 1980, '81.

CJ: Okay.

AF: In '80-'81 academic year. And, got much, so, got much more involved sort of DV over there. And came back here, spent another year working on the research grant before I went back to my clinical work, at which time, the (Inaudible) program director said, I'm so glad you came back to medicine.

CJ: Huh. The same one who had said that, that the suicide...

AF: Right.

CJ: Yeah, had nothing to do with medicine?

AF: Right, right.

CJ: Wow. Okay.

AF: And, so by, so we were still doing, yeah, so the research group kept going and I kept doing my residency, and so forth, but then by '85, we decided we were going to like quit doing the research bit and developed with a, with funding from the--what was it? The Connecticut, oh the, Department of Public Health and Addiction Service. Let's see, where did we first get funding for? That was to '83, '86--Yeah the Connecticut Department, first it was under the State of the Human, Human Resources, and the Department of Public Health. So for, for ten years the training program at, that we ran was supported by, the core support came from the, from Connecticut, and it was augmented by support from the March of Dimes and the Commonwealth Fund.

CJ: Okay. So that's a pretty significant shift then from the late '70s where people are, that don't know what a battered woman is, in terms of like medically speaking. And then in '85, the Connecticut Department of Public Health is funding you all to develop a training program.

AF: It is, it is amazing, and, and...I was sort of... Somewhere I came across it going through, I don't know. I mean I have--this is what--and the amount, the interest, this, this is just like from late '89 to '90, early '93...There were, there were probably 40 lectures that I did alone. And everywhere, everywhere from the, from national meetings of the American College of Physicians, and the American Medical Women's Association, to grand rounds at Harvard, to symposiums in Saskatchewan, Canada. Just everywhere. All, I mean, from, yeah the National Means as a Society of General Internal Medicine. Emergency Medicine. So, everybody was really wanting it.

CJ: So, finally, it seems like after a decade of work and research, the late '80s, early 90's...

AF: Yeah.

CJ: There's growing interest. Obviously, there's still problems from the medical field, but it seems like you see a really significant change in that time period.

AF: Oh yeah, because by now, there's a group of physicians, largely, some brought together through the AMA initiative. The, the group that wrote the, the 1992 clinical guidelines.

CJ: The guidelines? Yeah.

AF: And also the, the little green book. Do you have a little green book? The guidelines book?

CJ: Not at all. Okay.

AF: It's probably, I think it's, I think it's probably just a, a, pamphlet, or a booklet form of the... But it probably has some more stuff in it. I don't know where that is. But...In fact they were a group of physicians, women physicians who worked, mostly women physicians, who worked on...on that. And then, that became the core within the AMA of a larger group that did work on similar pamphlets on child abuse and rape, and domestic violence, all kinds of things like that. So you all, as physicians, like, did you get the sense that you were working mostly individually in different parts of the country throughout the '80s, and then you, you kind of all came together in the late '80s to do these, the guidelines within the, like is that kind of trajectory that's happening? Yes, and it's brought together, I think one example of that is '85, is when C. Everett Koop...

CJ: Yes.

AF: did the, brought everybody together into this national conference on injury control. But even then, they were not, there were, there were, it was another few years, it was really the AMA initiative in the '90s that brought...a, a cadre of young women, some of whom were already involved, others of whom it became an opportunity. It was really an organizing tool for them to become involved.

CJ: Okay. Yeah, and I was going to ask you about that.

AF: And it spawned another, another group.

CJ: Another, okay. Sorry, I didn't mean to cut you off.

AF: No, uh-huh.

CJ: I was going to ask you about that Surgeon General's workshop on Violence and Public Health, you know, you and Evan wrote about, you know, domestic violence for the source book. And so what do you think was the impact of that event? Do you think it, you know, do you have any thoughts about that event? Or, its aftermath, or you know, did you think it was really a critical? I mean, you've written that it was a critical moment, but if you could just expand a little bit about on like the impact of that workshop.

AF: Well, you know I think, you know, Koop's brilliance was to say that injuries are not accidents. That up until 1985, they were synonymous, you know, in healthcare. Everything else, I mean, healthcare, public health, and you had these kind of, you had the idea that, well seat belts might matter. So you had sort of industrial improvements that improved product safety. But it was through that product safety lens that any notion of engineering could impact injuries. And in '85, you still had the notion that it would be mechanical engineering that would make a big difference. Whereas, so, so some of it was about gun control. And obviously with the engineering of guns, engineering of gun locks, and so forth, and so on, so there's still room for mechanic--what I would call mechanical engineering on that. But, but, from my perspective, I think what's important about Koop's work is that he also, I hate to use the term "social engineering." But

he recognized the socio milieu as a, as a milieu that, through policy, through law, through culture in all different kinds of ways, you could shape, reconstruct, family networks, school networks, and so forth, into safer environments. And so, you weren't left with just the, the, the sick person with a gun...was the source of gun injuries, right? You had much more complex notions of, of social causality and power and control between men and women and so forth. Now, I think, do I think, do I think it made a matter. I think if Coupe had stayed in it would have made a big matter. But by the third National Injury Control Conference, and this boggled my mind this morning. The third injury control conference, which is 1991. Okay? It's about motor vehicle accidents, motorcycle safety, crash avoidance, roadway safety. There is a...

CJ: So is there nothing on violence and women, or...?

AF: There is the prevention of violence and injuries due to violence has now been subsumed into interpersonal violence, as one category, and suicide as another. And gender has completely disappeared.

CJ: So the first conference...

AF: Isn't that amazing?

CJ: So is the third, it was the first is this 1985 Conference on Violence and Public Health, and then six years later, it's all about motor vehicle crash safety, stuff like that? And, so-called interpersonal violence.

AF: Which is everything from gang violence to child abuse to, it's amazing. It's absolutely...

CJ: Well, it's amazing, because the source book from 1985 is child abuse, child sexual abuse, rape and sexual assault, spouse abuse, violence against the elderly. I mean, that's the entire program.

AF: Yes.

CJ: Right? And there's homicide and public violence, and then you get, six years later, and it's--so what do you think is going on that, is it--what happened that it... It's strange, because at the same time that you see medicine beginning to address violence, you then see these, this larger national conference--violence against women and battering--you then see this larger national conference start to dismiss it? It disappeared. Gender disappears.

CJ: Yeah, gender disappears. Yeah. Wow.

AF: Gender disappears.

CJ: Yeah.

AF: And the other thing that disappears, it is, I think it's the, it is the, so, and, and it was a political, political decisions. About gender disappearing and about gun control disappearing. Because Art Kellermann, who was the, who was heavily, he was heavily funded, I think by the CDC. But he was in Atlanta--he's an ER doc--did beautiful, beautiful work on gun control and looking at, he did a comparison study between Seattle and Vancouver. Are, those are the two cities on either side, right? And Vancouver has gun control, Seattle doesn't. And looking, look, just comparing murder. It was a brilliant study and it brought the NRA right smack down on top of his research.

CJ: Oh yeah, that's not a surprise, right?

AF: Yeah, yep.

CJ: And they weren't, I'm sure they were not happy with him.

AF: Right, right. And in, in this... This basically highlights black males. And, so you see, you know, gang violence, and you know, is that the, is that the early, is that what we see now, the, with the extraordinary

rates of imprisonment, incarceration, and the development of a private prison system, a for-profit prison system...to incarcerate a larger minority community? So that, so that the, the whole, the, so that the politics of, and I'm being very, I mean I don't really know this stuff, about, about this stuff, but it just looks interesting. In light of that. And there continued to be, I mean, you know, states took on family violence, and there's certainly, you know, a continuing and mounting awareness of family violence. But it's suspiciously absent from the Centers for Disease Control.

CJ: Interesting.

AF: Yeah. It, it's, and I don't know those individuals well enough to, you know, hear their side of the tale and what kind of pressures they were under.

CJ: Right, and why, yeah, why you see this disappearance by the early '90s.

AF: But at the... Well, but at the same time, the early '90s is then when the AMA got involved.

CJ: Right, exactly. So, it's kind, it's a lot, it's very complicated, right?

AF: And you, and the medical subspecialties became increasingly involved. And, now I did come up with Martha Whitwer's name. Martha was a staff person at the AMA. And the real driving force who must be mentioned--Oh, where's my cards?

CJ: And, Martha, is it Whitmere, W-H-I-T-M-E-R-E? Oh.

AF: Whitwer, W-H-I-T... I said I would find, I said I would, [mouth noises]... Alright, I'm going to have to send you, well you want it in the, in the video, I mean you want it in the thing.

CJ: I can also do adjustments, or we can add, so.

AF: You can add (Inaudible) to it. I can...

CJ: Yeah, like if there's a name that you're remembering. But, Martha, I'm sorry, Martha's last name was W-H-I-T?

AF: T, W-E-R.

CJ: Oh yeah, to Whitwer, okay, got it.

AF: Let me see if...

AF: Yeah, Whitwer. Let me see if it's in, 3.4, let me just see if it's in this issue.

CJ: Okay.

AF: If they mention his name.

CJ: Yeah, I'd like to ask you some more questions about that AMA Diagnostic and Treatment Guidelines that you co-authored. You know, I mean obviously, this is really a significant moment, so did you all see this as a moment of victory of, you don't think considering the work you all had done, both individually and starting like a, a groups of physicians throughout the country. Just the experience of having the AMA publish those guidelines like, how did, what did that feel like for you?

AF: Well, I think what, what was, what was, what felt really important was not only that they published the guide, but they had brought us together month after month after month to meet there and talk about what could be done and to fill in, fill their staff members in on what should be done, at, which was a tremendous expense at their point, which is why I have to find...(Background Noises) Oh yeah, you have

to find the...Okay, and you don't have the little green...the person.You have don't have the little green book right there with you, do you? Oh, wait, wait, wait, here...

CJ: I don't.

AF: Here it is. No. The guide, I think these treatment guidelines are not the same as the Scientific Council ones. Okay, yeah, now Susan McCleer, was a ER doc who did really great early work in the emergency room in Philadelphia. And Carole Warshaw is, she's like a genius, she's triply boarded in ER psychiatry and internal medicine, or something, and is a wonderful feminist, and runs programs in Chicago. She was very, but let me see. I know it was (Inaudible). Okay, Marshall, M-A-R-S-H-A-L-L D. Rosman, R-O-S-M-A-N, Ph.D. He's a Ph.D. in sociology. And, and the second really active person was Roger L. Brown, Ph.D. But I don't know what his Ph.D. is in. But, Martha Whitwer, W-H-I-T-W-E-R, was a master's in public health, and she was, she was, Marsha was a, a staff person, had been for years, a staff person at the AMA. Martha was more recently brought on, but this whole doing something about violence against women was a conspiracy by Marshall Rosman and Roger Brown and Martha Whitwer to get the AMA involved. And they did it by...

CJ: So they were really the movers and shakers?

AF: They were the movers and shakers. And they shook them, they shook the money tree out of the AMA, and they got the senior leadership of the AMA on board with all this stuff.

CJ: That's pretty incredible.

AF: They were really amazing. Yeah. They found us. We came together and looked around and we said, my God, none of us are members of the AMA. (Laughs) Which didn't seem to bother them at all. It didn't seem to bother them at all, but you'll notice that the scientific and treatment guidelines that are published in JAMA are written by the scientific review committee of members who are all members of the AMA.

CJ: The AMA?

AF: Yeah.

CJ: Okay.

AF: Right, right, right.

CJ: Interesting.

AF: Although, I, yeah, so, so there's some, but, but, but, Marshall was so great, and Martha was so helpful in doing any, you know, that, we very quickly got over our, whatever feelings we had about the AMA. And felt they could do really good stuff. And I think it was on the back of the AMA's involvement that you then got the joint commission on the accreditation of hospitals. Which, you know, makes sure hospitals are clean and safe and so forth and so on, to begin putting in questions in emergency room services, and other services, in every encounter, about are you safe at home.

CJ: Excuse me. So, that's, so it's, it's like the AMA guidelines kind of have this, I don't if you would call it a domino effect, like that happens, and then that pushes the joint accreditation, so that...

AF: Yes.

CJ: Okay.

AF: Right, right.

CJ: So, this is, so this, the AMA, this is a huge deal? Yeah.

AF: This gives the imprimatur of real medicine. This, this gives, I don't know how that goes, this gives the issue the imprimatur of real medicine. But anyway, this, this, this says, violence against women is, domestic violence as it was called then, is real medicine. And in the wake of that then, the guy named Ed Brandt, B-R-A-N-D-T...Who was at University of Oklahoma. He had been an under-secretary at H E W. Now, I can't, maybe in Carter's administration, he'd been an under-secretary. And then went out to, then, and then sort of, then--I think he was from Oklahoma--after, after his Washington stint was over, went out to University of Oklahoma, and was in like the dean's office, or something like that. But he was very, very networked with the licensing, the whole process of how doctors get licensed, and the licensing examinations, and, and medical school curriculum, because that was the next place to go with it, was medical school curriculum. And, the American College of Physicians wrote a whole text on (Background Noise) It's upstairs. I mean of course, Amwell (phonetic) was very busy all this time.

CJ: Oh, also they're doing a text on medical school curriculum, or DV?

AF: I'm pretty sure it's just on, I don't, I don't, maybe it's women's health, generally. Let's see.

CJ: You're going to go find it.

AF: (Laughs). It's somewhere.

CJ: And the '90s seems to be... The early '90s you also have the development of forensic nursing. It seems like the '90s is really like a boom time for...

AF: Well, forensic nursing may have gotten its credentials in the '90s, but it's roots go back to this woman, Barbara Moynihan, whom Bill Fraser wanted me to work with in 1970, at Yale.

CJ: Oh, and she was the one doing rape, rape crisis work, right?

AF: She was the one who started the rape crisis team at Yale. Yes. Yeah, so.

CJ: Yeah. And I've, I've spoken with Linda LeDrey who did the sexual assault nurse examiner program here in Minneapolis in '77, I believe. But, yeah the roots of forensic nursing are those same programs and...

AF: Yes.

CJ: Yeah, all that kind of stuff.

AF: Yeah, yeah, yeah. So, so you begin to see it move into the curriculum, and Ed Brandt hosted a meeting in--could it be Oklahoma City?--on the question of what belongs in the medical school curriculum. And people like Elaine Alpert--have you talked to Elaine?

CJ: No.

AF: Elaine is at, is she Brigham and Women? (Background Noise) And you know, do you have, you have access to, you can do a search for Elaine Alpert, right?

CJ: Yeah, I can find her.

AF: In academic medicine? Do you have access to academic medicine?

CJ: I don't know that I have... I mean, I might be able to through my networks. But I'm sure I could track her down, somehow.

AF: Yeah, she, she was in the dean's...

CJ: After all, I did find you. (Laughs) I feel like I can find people.

AF: Elaine is...(Background Noise) Nuts, I'm sorry. I was just reading that book this morning.

CJ: But she was one of these people who was involved in the...

AF: She was very...

CJ: curriculum development?

AF: involved in the Oklahoma meetings.

CJ: Yeah, okay.

AF: very involved in the Oklahoma meeting.

CJ: Okay. And is this Oklahoma meeting, are we talking like mid-'90s, at this point?

AF: We, we must be.

CJ: Yeah, yeah. Okay. Because that seems to be like the next major frontier, I think, like in this story, right? It's the curriculum and training...

AF: Yes.

CJ: medical personnel; physicians, nurses, et cetera...

AF: Right.

CJ: in. Right. Okay.

AF: And it was Ed who taught us that if the questions were on the licensing boards, then the deans would put it in the curriculum. See, we all thought that sort of the way you'd get in the curriculum you would convince people it was such an important thing, and you couldn't take care of women very well unless you were able to do, you know. And we thought that's how things worked. Well no. That's not how things work. (Laughs) You really couldn't care less about that. They wanted to know what would, what would be, what were my students going to need to know in order to pass the exam.

CJ: Exactly. So yeah, so that's the strategy. It's like get it on the boards, and then you can get it in the curriculum (Inaudible)?

AF: Exactly. Exactly.

CJ: So, whether it's important or not, it's about the test.

AF: Exactly. Exactly.

CJ: Yeah. Okay.

AF: So that's how that went. And, and I think, and it's about that time that I got more and more involved in my clinical work. Less and less involved in doing training stuff. And Elaine really did a tremendous amount in terms of training. She went on to work with Massachusetts Medical Society and did a whole set of CDs. : I wonder what tells where she is from. Let me see. (Background Noise)

CJ: On that, and then, yeah, a few more questions, keeping us back into the '80s, after you figure out Elaine Alpert's situation.

AF: I would try and track her down through the Massachusetts Medical...Society.

CJ: Okay.

AF: But she's an MD and an MPH. And it's A-L-P-E-R-T.

CJ: Okay. That's great, thanks. So, going back in the, looking in the late '70s and the 1980s and, so you see physicians working mostly individually--and correct me if I'm wrong on this. You have nurses working mostly individually, social workers are getting involved, MPHs, you know, or people with master's in public health and, do you see... I mean are there any collaboration between say physicians and nurses? Or, or are you all mostly working separately? You know. I'm trying to fuse together this history.

AF: Well, the nurses were very well organized. I'm sure Jackie talked to you about the National Nursing Network.

CJ: Yeah, I have an interview. I did not interview her, but I have the interview that somebody from the National Library of Medicine did with her. And I interviewed Dan Sheridan, so I, I, you know, I have the sense of the nurses' story. Yeah.

AF: Right, right. So I, and I think the, the nurses were... It was, domestic violence, violence against, was not an area where, because it wasn't accepted by medicine...Like my, my chairman, after I got promoted to associate professor, said to me, well, you'll have to be the queen bee of something else to get promoted to full professor. So, it wasn't a issue. And, Elaine for instance, who was also on a ten-year track position, she moved over to administration. And then, as an administrator she was much freer to pursue that as a professional. You know, that she wasn't, that her, that her dean promotions didn't come from the quality of her work but rather, probably, to a certain extent, the quality of her community contributions which were tremendous.

CF: And, when you had this person say to that you had to be queen bee of something else, what, what year are we, I was just, what year are we talking here, just so...

AF: We're talking, we are talking, we must be talking 2000.

CJ: Oh, that late. It's 2000.

AF: Yeah. Yeah.

CJ: Okay.

AF: Yeah. Now maybe...I mean, and, and, it's just not an issue... While there are, in pediatrics, there are many, many prestigious pediatricians who have been promoted, and their life work is in, work with abused children. But, in internal, in internal medicine, it's not, it's not a recognized... Now maybe if I, if I lived my life over again and I did clinical work with women who were in an abused relationship, and had a team, like Susan Shechter's team with child abuse. But it, I, you know, I worked at a little, a clinic. I, I, there wasn't, that wasn't going to happen. So, I, I, I can't really, I think it was a lot of individuals. And we knew each other. We liked each other. But we, we didn't have a national organization that did research and published research articles and so forth and so on.

AF: We drew upon each other to do rounds at each other's hospitals. My impression is that the National Nursing Network was much more organized. And I think it had to do with the fact that you could get promoted.

CJ: Oh, in nursing, right.

AF: Yes, right.

CJ: Whereas you all couldn't get promoted because the issue wasn't taken seriously enough?

AF: Right.

CJ: At your level.

AF: I mean, to that, well, I mean, and you have to realize that, you know, sort of, well, that the position of women in medicine, too.

CJ: Oh right, of course.

AF: That we were not the first generation of women. There's certainly a huge number of women who'd come before us. But to, I guess maybe, to, to come out on feminist issues as women in, it was... I didn't do it. (Laughs)

CJ: Well, I mean, you did right, in doing all your work on abused women?

AF: But I did it in part because, in large part because I felt like, and I still feel like, how can you, how can you, you... Some women comes to you to your office with a headache. How can you even begin to know what the headache is from if you don't ask her if she's in the relationship where she's hurt, or frightened, or when there's fights at home, is she hurt, or afraid? Or, in the past has she been in a, has she suffered, like... How do you, do you have to do that? Or somebody whose, you know 30, and their right shoulder is totally gone and they were not a high school and a college softball pitcher. Well, how did you're right shoulder get so continually injured? You have to ask. Have you suffered injuries? You know. To me, you just can't take care of people without knowing their adult trauma history.

CJ: But...

CJ: Although in the '70s, that wasn't the concern, right? I mean, I've got, I think (Inaudible)...

AF: That's right...

CJ: and I pulled (Inaudible)...

AF: That's right...

CJ: of your articles of...

AF: And to a certain extent...

CJ: yeah.

AF: And to a certain extent, you know, that's sort of where I parted with... Eventually, kind of my interests began to part from other people's interests who were, who were, who were more focused on violent, you know, providing safety for women and safe encounters, and so forth and so on, that I really saw it as something that needed to be deeply embedded in the basic, "Hello, my name is doctor, and how can I help you?" framework. Because otherwise, I don't believe you can understand what makes the people you're taking care of tick. You know, so, and that continues to be the most interesting piece of it to me. Anyway.

CJ: Like, the piece, the piece of really getting at the root of the issue, which is the most interesting to you?

AF: It's how, it's how profoundly being abused, whether you're being physically hurt, being emotionally hurt, being psychologically constrained, however you want to say it. The profound effect that has upon your health and well-being. And, therefore one who is involved in facilitating health and well-being needs to know...whether that particular issue is functioning in your self-capacity. So, I think. Anyway... So I, I, I read a lot of medical humanities (Laughs) these days.

CJ: Yeah, I kind of (Inaudible).

AF: Well, because I think literature, literature is well aware of the, the ways in which coercion and control create tragedy, and, and constrain well-being. So...

CJ: Okay.

AF: You have more questions?

CJ: So the work continues.

AF: Right. Yes, yes, yes, yes.

CJ: Yes, yes. Well, let's see, we've been on the phone for about an hour and a half, so I do want to be (Laughs) a winner of your time. But this has been, this has been really great to get, you know, a sense from the physician's perspective of, you know, and then particularly with somebody who was one of the very first to be doing this cutting-edge research, and to get a sense of this change over time in the medical profession. So, I really appreciate all this information. It's, it's, it's really awesome, for lack of a better word, to hear this history from you. I mean, it's, it's like, it is awesome in terms of what you've been able to do. You and other physicians, and nurses, and so, yeah, I really appreciate talking to you. So, I think, yeah, at this point, I think I'll look over the notes, and if I have further questions, you know.

AF: Sure, email me and (Inaudible)

CJ: (Inaudible) shoot you an email.

AF: We can set up another time and I'll get, and I'll charge my phone this time. (Laughs)

CJ: Okay. Yeah, no problem. And then, if there's anything, also, you know, that you think of that you forgot to add, that you want to mention, or whatever, feel free also to shoot me an email and we can make sure everything gets in the record.

AF: Okay.

CJ: Yeah. That's great. Anne, thank you so much. This has really been amazing to hear your story and your life's work and I really appreciate it.

Cut here at 1:27:26