The Evolution of INTIMATE PARTNER VIOLENCE

As an orthopaedic medical entity

IMPLICATIONS FOR TRAINING AND PRACTICE

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HOW DID INTIMATE PARTNER VIOLENCE (IPV) EVOLVE INTO AN ORTHOPAEDIC MEDICAL ISSUE?

ABSTRACT

BACKGROUND: What society defines as a health and/or a medical issue changes over time. Medicalization of behaviors and of social problems was a characteristic of the twentieth century in the United States, expanding the scope of medicine. Medicalization transforms healthcare by redefining expectations of and practices by health care professionals. This essay explores how care for Intimate Partner Violence (IPV) victims evolved into an orthopaedic medical entity and then considers the implications for training and for practice.

METHODS: Oral history interviews with two orthopaedic surgeons, Mohit Bhandari at McMaster University and Debra Zillmer at Mayo Clinic, who have led pioneering efforts to improve IPV awareness, response, and advocacy in their specialty were combined with (1) primary and secondary literature reviews and analyses, with (2) background research
in the historical archive at the Futures Without Violence organization in San Francisco, California, and with (3) interviews and conversations with Lisa James of Futures Without Violence and with Jacquelyn Campbell of The Johns Hopkins University School of Nursing.

**RESULTS:** Until the 1970s, IPV was primarily a criminal justice issue, not a medical issue. Starting in the 1970s, “wife beating” (later called “domestic violence” and then “intimate partner violence”) emerged as a major public health issue. This paradigm shift set the stage for individual orthopaedic surgeons to take up the cause as an opportunity to improve patient care for victims of violence and abuse. As medicalization agents, they have shaped medical culture, establishing the current expectation that orthopaedic surgeons should screen for and respond to IPV as part of standard patient care. This emergence story has evolved as an updating function, with dynamics of the preceding stage(s) bleeding through into and embedding within the next one(s): (1) Justice Stage: cultural awareness of IPV as a social justice issue; (2) Public Health Stage: recognition of IPV as a health issue; and, (3) Clinical Medicine Stage: generation and implementation of specialty-specific clinical medicine tools and policies and training resources for education. During this history, individual healthcare leaders determined that IPV is a
social issue that affects people’s health states significantly and therefore is a human condition that warrants responses in medical settings, including in orthopaedics. Yet, this rapid rate of medicalization has outpaced training, creating knowledge gaps in clinical practice.

CONCLUSION: This historicized discussion of the medicalization of IPV illustrates the close interrelationships between medicine and society and how a particular health issue first gains recognition and then shapes medical practices and policies, as occurred in orthopaedic surgery. The evolution of IPV from a justice to a public health to a clinical medicine issue creates a tripartite framework that could be applied to the training of current and future orthopaedic surgeons. Various moments and aspects from all three stages of this complex, multi-faceted history continue to bleed through today to determine and shape the skill sets that orthopaedic surgeons need and should develop accordingly.
CHAPTER 1

Introduction, purpose, and methods: the skeletal bones to hang the meat on

Ants in their pants

Years ago, active children who squirmed in their seats in school simply had “ants in their pants”—not a human condition that required medical treatment. Today, however, many hyperactive kids are labeled with Attention Deficit Hyperactivity Disorder (ADHD) and are assigned a pharmacological treatment course to curb their “deviant” behaviors—that is, deviant according to current cultural standards; what society defines as “deviant” shifts fluidly throughout history. The evolution of a common characteristic in people—a short attention span, for example, coupled with a strong drive for activity—into a medical entity illustrates the process of medicalization. In general terms, medicalization is the process by which any human condition morphs into a medical issue to be formalized and labeled as a disease, illness, diagnosis, condition, syndrome, or health-determining factor¹.

Once the prevailing medical culture accepts a human condition as a medical issue, treatments and management plans—interventions—emerge to prevent it, to fix it, or to mitigate its perceived negative effects on health and well-being—and, perhaps, on human dignity, as well. Responding to this new medical issue becomes, in part, the responsibility of the people working in healthcare systems: physicians, surgeons, nurses, and other health care professionals (HCPs). Defining medicalization as a process—as evolution—means that it is neither an improvement nor a problem for society a priori; instead, as the scope and nature of society’s views on health and disease change over time, it simply plays out, for better or for worse.

Specifically, for orthopaedic surgeons, medicalization changes the roles that they play both in healthcare systems and in society at large: it alters society’s expectations of them as healers; it transforms (and typically expands) their responsibilities as clinicians, in many ways, including morally, ethically, legally, administratively, economically, clinically, and in terms of policy. Medicalization is a powerful history concept because it challenges people involved in the management and/or the delivery of healthcare to view their purposes as dynamic—and, as subject to external forces of influence.
Raison d’etre

*Essays are attempts*: This discussion attempts two things. It attempts, firstly, to recount and to explore how Intimate Partner Violence (IPV) evolved from a human condition—in this case, a private interpersonal issue—into an orthopaedic medical issue that orthopaedic surgeons are expected to be knowledgeable about, to screen for, and to respond to appropriately. It attempts, secondly, to consider the implications and the applications of this history for the training of current and future orthopaedic surgeons.

*The skeleton*: Today, IPV represents a significant health-determining factor; it is perceived commonly as a public health issue with orthopaedic care implications. In the United States and in Canada, orthopaedic surgeons are now strongly encouraged by their national orthopaedic associations to educate themselves about IPV and, as part of standard clinical practice, to implement tools and protocols for providing care to victims of violence and abuse. However, it has not always been this way in the United States or in Canada. Something happened between the 1970s and now; that something is the medicalization of IPV. Today, an

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2 This essay focuses on females as patients, but males are also victims of IPV. IPV crosses all social boundaries.

orthopaedic surgeon must be “skilled”—educated and trained properly—to screen for and identify IPV and to respond appropriately. This is a result of an evolutionary process that has progressed since the 1970s in three overlapping stages:

(I) **JUSTICE STAGE:** Up until the 1970s, society criminalized IPV, referred to it as “Wife Beating” (or by other such labels as “Wife Battering” or as “Spouse Abuse”), and viewed it primarily as a private interpersonal issue that the justice system should monitor, respond to, and control.

(II) **PUBLIC HEALTH STAGE:** Starting in the 1970s, the first step (Step 1) in the medicalization of IPV gathered momentum as a confluence of cultural, political, and socioeconomic forces combined with individual advocacy efforts by battered women’s movement activists and by healthcare leaders to re-characterize IPV as a health issue (as “BWS: Battered Woman/Wife Syndrome,” for instance, according to Walker and to others like Parker and

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Schumacher\textsuperscript{10}). This transformation expanded the boundary of the medical system to include IPV in its purview. As a result, Health Care Professionals (HCPs) were entrusted with the general responsibility to screen for and respond to IPV. In this process, IPV advocates shifted the definition of IPV and changed the term used to refer to it to “Domestic Violence.”

**(III) CLINICAL MEDICINE STAGE:** From the late 1980s onward, various medical and surgical specialties—such as emergency medicine early and orthopaedic surgery later on—(a) focused on how to “diagnose” and to “treat” IPV with setting-specific clinical protocols and practice tools, (b) embraced the new term Intimate Partner Violence (IPV), and (c) emphasized the unique constellation of circumstances that make each IPV patient case distinct.

From a mathematical point-of-view, this history of the medicalization of IPV developed iteratively via an updating function: each subsequent stage added to and embedded within the previous stage(s), changing the nature of IPV along the way, producing the following tripartite framework results (which, of course, were quite complex and

messy and were intertwined intricately in the real-world realities of time and space):

(I) Justice = Wife Beating / Spouse Abuse
(II) Justice + Public Health = Domestic Violence
(III) Justice + Public Health + Clinical Medicine = Intimate Partner Violence

Today, moments and aspects from all three of these stages bleed (and, sometimes even hemorrhage\(^1\)) through in important, meaningful ways to determine and to shape the skill sets that orthopaedic surgeons need to care for patients who are victims of violence and abuse. An orthopaedic surgeon needs to understand and to be competent with the legal, the public health, and the clinical medicine aspects of caring for an IPV victim as a patient.

**Implications for “skilling” current and future orthopaedic surgeons:** In 2013, orthopaedic surgeons have highlighted the need for improved IPV education in their specialty in order to bridge the knowledge gaps\(^1\) that exist as a result of the rate of the medicalization of IPV far outpacing the creation and implementation of requisite training modalities and experiences in parallel. This temporal mismatch has

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contributed to misperceptions about IPV in orthopaedic surgery. Recently, Della Rocca et al. found in a survey of surgeon members of the Orthopaedic Trauma Association (OTA) that “[o]rthopaedic surgeons had several misconceptions about victims of IPV and batterers,” which led to the conclusion that “[t]argeted educational programs on IPV are needed for surgeons routinely caring for injured women.” In response to this publication by Della Rocca et al., Leopold reflected: “This month we learn from Dr. Della Rocca and colleagues that orthopaedic surgeons continue to endorse a number of mistaken beliefs about the victims of intimate partner violence (IPV), and that only approximately one in 25 of us screens patients for IPV regularly. Although orthopaedic clinicians are positioned perfectly to discover and intervene, as a group, we do not do it. We have seen studies and heard calls from our Academy for some time.

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now. The message has been consistent over a period of years. Why are we not getting it?”

To help close these knowledge gaps, this story of the medicalization of IPV could be operationalized as a framework for teaching. Understanding how IPV evolved into an important contemporary orthopaedic medical issue could prove constructive in addressing why orthopaedic surgeons should be aware of, respond to, and advocate for IPV victims as patients. In turn, this approach could enroll more current and future orthopaedic surgeons in the noble vision to *embrace IPV as an opportunity to intervene positively in patients’ lives.*

**Modus operandi**

To investigate this topic, I (Brent) reviewed the primary medical literature on IPV and some of the secondary literature on topics like medicalization and social movements. I also conducted oral history interviews with two orthopaedic surgeons—Drs. Debra Zillmer and Mohit Bhandari—who

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have served as leaders on IPV awareness, response, and advocacy in orthopaedic surgery, participating directly in the medicalization of IPV in their surgical specialty. Zillmer\textsuperscript{19} is an orthopaedic surgeon at Mayo Clinic, and she got involved with IPV advocacy while spearheading the Ruth Jackson Orthopaedic Society (RJOS), a group for female orthopaedic surgeons and for female musculoskeletal health issues. As this discussion will reveal, Zillmer is an IPV pioneer in orthopaedics; she published and presented about this topic when others were either ignoring or were unaware of it—she shined light on darkness and opened her colleagues’ eyes to a neglected issue. Building on Zillmer’s early leadership in the United States, Bhandari\textsuperscript{20}, an orthopaedic surgeon at McMaster University, has spoken up in Canada and globally to help break the silence on IPV by leading research efforts on this topic. He has enlightened the field of orthopaedics by exposing longstanding misconceptions and misperceptions about IPV and by developing and implementing approaches to help close IPV knowledge gaps. His passionate work to medicalize IPV most optimally has improved patient care and has established an academic foundation upon which current

and future orthopaedic surgeons can build to further
determine how best to approach IPV in orthopaedics.

Lastly, following an inspiring conversation with Dr.
Jacquelyn Campbell\(^{21}\), a professor at The Johns Hopkins
University School of Nursing who has served as one of the
leading IPV advocates and research scientists globally for
decades, I visited and perused the historical archive at the
Futures Without Violence nonprofit organization’s
headquarters in San Francisco, California. While there, I also
met with Lisa James\(^{22}\), the organization’s Director of Health,
to discuss the history of IPV in the United States healthcare
system. Futures Without Violence has played a central role in
the battered women’s movement, shaping the medicalization
of IPV in significant ways.

**Caveat**

I am biased. Personally, I believe that the
medicalization of IPV in orthopaedic surgery at this point in
history has been a good thing—a net positive for society. I
think that orthopaedic care for victims of violence and abuse
could be improved by communicating more often about this

\(^{21}\) Jacquelyn C. Campbell, PhD, RN. The Johns Hopkins University School of Nursing. Accessed on 17 March 2013
<http://nursing.jhu.edu/faculty_research/faculty/faculty-directory/jacquelyn-campbell>.

\(^{22}\) Lisa James, Director of Health. Futures Without Violence. Accessed on 17 March 2013<http://www.futureswithoutviolence.org/userfiles/file/PublicPolicy/PublicPolic
y/Speaker%20Bios.pdf>.
important issue. In the discussion that follows, I always err on the side of advocating for IPV victims and for the healthcare leaders who have taken up this cause with energy and enthusiasm as an opportunity to make a positive difference in patients’ lives.
CHAPTER 2

The history of the medicalization of IPV: the meat

Medicalization of IPV

Medicalization provides a conceptual framework for understanding the evolution of IPV from a social justice issue into an orthopaedic medical issue. According to Conrad, “[I]n the past fifty years […] the jurisdiction of medicine has grown to include new problems that previously were not deemed to fall within the medical sphere”\(^{23}\). This trend characterized medicine in the United States in the twentieth century, expanding the scope of healthcare significantly. In turn, changes to the boundaries of medicine transform HCPs’ roles in society by redefining their clinical responsibilities and their day-to-day activities.

It is possible to forget the fact that what society deems to be medical issues currently have not always been perceived that way for eternity. Commenting on this fact, Conrad states that “[t]he main point in considering medicalization is that an entity that is regarded as an illness or disease is not ipso facto a medical problem; rather, it needs to

become defined as one.” From the twentieth century, two examples of nonmedical issues that have been redefined in healthcare terms are (1) Alcoholism and (2) Attention Deficit Hyperactivity Disorder (ADHD). Over time, alcoholism morphed from a personal issue that affected an individual’s lifestyle and relationships with others into a behavior-altering addiction that affects human physiology so significantly that it represents a primary risk factor for many illnesses and thus warrants evidence-based counseling and treatment by physicians. More recently, ADHD shifted from an issue that teachers and parents managed locally—these children needed to move more often throughout the day; that is all—into an illness that physicians treat actively (and sometimes aggressively) with drugs and other medical therapies. Similarly, leading up to the 1970s, IPV was a nonmedical issue that partners dealt with on their own terms; even law enforcement avoided involvement in what was perceived by society to be a private affair. Since the 1970s, the medicalization of IPV has changed everything. It is important to note, though, that although HCPs’ scopes of practice expanded as a result of these human conditions evolving into medical entities, HCPs did not drive these metamorphoses alone. In many ways, HCPs were swept up by social

24 Ibid., 5-6.
25 Ibid., 147.
movement waves—waves that crashed to shore, leaving knowledge gaps in their wakes as the tides receded.

Social movements influence medicalization profoundly. In fact, according to Conrad, it is critical to recognize that “[w]hile the medical profession often has first call on most maladies that can be related to the body and to a large degree the psyche, some active agents are necessary for most problems to become medicalized.” In the case of IPV, as this historical discussion will show, diverse members of society exercised agency within the contexts of the civil rights, feminism, AIDS, gay rights, and patient empowerment movements that shaped people’s mental models and psyches during the 1960s, 1970s, 1980s, and beyond to raise awareness of IPV as another important human rights issue that also has serious effects on health. Conrad views this health issue emergence pattern as common, pointing out that “diagnostic advocacy is often accomplished in some association or connection with an extant social movement: PMS with the women’s movement; PTSD with the Vietnam veterans movement; and AIDS treatment with the gay and lesbian movement. In each case the explicit politicization and mobilization of the social movement propelled the new category forward.”

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26 Ibid., 6.
27 Ibid., 9.
medicalization often start out exerting their influence on the periphery culturally as members of the lay public participate actively in social movements and identify causes in need of advocacy; in turn, these advocacy efforts first raise awareness of a problem in society and then, in the case of health-related topics, stimulate this awareness within healthcare systems.

In time, HCPs recognize the health implications of these human conditions and move to incorporate responses to them into clinical practice. As Conrad observes, “Medicalization [is] more complicated than the annexation of new problems by doctors and the medical profession. In cases like alcoholism, medicalization was primarily accomplished by a social movement (Alcoholics Anonymous), and physicians were actually late adopters of the view of alcoholism as a disease”28. Therefore, when analyzing medicalization in a specific case, late adoption by physicians or surgeons is not necessarily (or inherently) a good or a bad thing—a moral judgment is not implied—it is simply a pattern of emergence. In considering the consequences of medicalization, it is critical to remember that “[…] by expanding medical jurisdiction, medicalization increases the amount of medical social control over human behavior”29. In the case of ADHD, medicalization has

28 Ibid., 6.
29 Ibid., 8.
granted physicians the ability to control people’s daily activity levels significantly by prescribing mind-altering pharmacological therapies. Some people (myself included), contest medicalization playing out in this fashion in this case and disagree strongly with giving physicians this social control ability—instead, society should manage kids with “ants in their pants” through environmental-based, non-pharmacological approaches, these critics may contend. In the case of IPV, medicalization has entrusted physicians and surgeons (and other HCPs) with the responsibility to respond compassionately and appropriately to victims of violence and abuse, which includes listening to these patients’ stories empathetically and counseling them on how to operate amidst the uncertainty of dangerous relationships. Consequently, today, one could say that HCPs have become IPV victims’ co-captains in their journeys to navigate the treacherous seas of IPV safely. In cases like ADHD and IPV, in lasting ways, medicalization has fundamentally redefined what it means to be an HCP in society.

Interestingly, offering a historical perspective, Conrad highlights two keys to medicalization that blossomed in

30 Note: In this essay, I attempt to de-politicize medicalization and to instead redefine it simply as an evolutionary process that occurs when social issues become health issues that our healthcare systems respond to in some capacity. There are pros and cons to medicalization that differ on a case-by-case basis. Ultimately, HCPs have a responsibility to attempt to shape the trajectory of medicalization most optimally. In some cases, that calls for de-medicalization.
society in the 1970s and 1980s. Firstly, HCPs’ power in society increased; and, secondly, social movements and interest groups fueled the process—“[i]n general, organized grassroots efforts promoted medicalization”31. Connecting the dots, if grassroots movements fueled medicalization initially, HCPs’ late adoption trends could represent logical decisions to resist—or to delay or to limit the scope of—expansion of medical practice into domains that ultimately do not warrant healthcare intervention. Perhaps, some physicians or surgeons may argue, these human conditions could be better addressed through other social mechanisms. To this end, Conrad shares the following reflection about medicalization: “One of the major goals of the medical profession, and of many physicians in practice, is to reduce the suffering of individuals. [...] Yet one can also ask the question, What are the limits to medicine’s role in reducing suffering? Clearly, medicine is not directly involved in reducing financial or ethnic suffering, but the limits of medical suffering are not clear”32. It turns out that, in the case of IPV, over time, many HCPs reached the same conclusion that those involved in the battered women’s movement did: IPV influences patients’ health states significantly and thus

31 Ibid., 9.
32 Ibid., 157.
warrants evidence-based responses as part of standard patient care.

**The epidemiology and health impact of IPV**

Intimate Partner Violence (IPV) includes sexual violence, physical violence, stalking, psychological aggression, and control of reproductive or sexual health\(^{33}\). An “intimate partner” is any former or current dating partner or spouse\(^{34}\). IPV affects people from all walks of life. In 2011, Black et al. at the United States Centers for Disease Control and Prevention published the results of The National Intimate Partner and Sexual Violence Survey: 35.6% of women in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetimes; and, more specifically, 32.9% have experienced physical violence by an intimate partner\(^{35}\). In addition, this survey gathered that 28.5% of men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetimes\(^{36}\).

Many patients suffer from health issues related to abuse. These health challenges may present in various ways

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\(^{34}\) Ibid.

\(^{35}\) Ibid.

\(^{36}\) Ibid.
that range from acute trauma injuries to chronic conditions like pain that will not go away\textsuperscript{37}. Economically, the cost of direct medical care and mental health services related to IPV in the United States exceeded $4 billion in 2003, which translates into a much larger expense in 2013 dollars\textsuperscript{38}.

\textit{Net result}: This epidemiological introduction shows that IPV is a medical issue.

\textbf{IPV is a current topic in medicine}

Before looking back at how the medicalization of IPV evolved in the United States healthcare system, it is informative to look first at a recent development that promises to shape the future of IPV patient care by altering how medical schools evaluate pre-medical students.

The Association of American Medical Colleges (AAMC) makes changes to the Medical College Admissions Test (MCAT) infrequently. When it does, it signals a historical shift in perspective. Starting in 2015, the MCAT—in only its fifth iteration since its creation in 1928—will include sections to assess students’ social and emotional


maturity levels\textsuperscript{39}. According to Steven Gabbe, Chief Executive Officer of The Ohio State University Wexner Medical Center, who chaired the Association of American Medical Colleges’ committee charged with crafting the MCAT changes, “Because doctors see patients who face problems like domestic violence, substance abuse and divorce, […] it’s crucial that medical students recognize how such factors affect health. Understanding the way people live day-to-day will help doctors better communicate with patients”\textsuperscript{40}. This overhaul of the MCAT demonstrates concretely the prominent roles that social issues like child, intimate partner, and elder abuse play in modern medical care. Medical educators realize that medical students, residents, and fellows must be prepared to care for victims of violence and abuse compassionately and effectively. These changes to the MCAT exam crystallize a shift in perspective that has progressed iteratively over the past few decades as IPV morphed into a medical issue that physicians and surgeons are expected to be aware of and respond to professionally as part of standard patient care.

\textit{Net result:} The Association of American Medical Colleges (AAMC) is playing an active role in shaping the

\textsuperscript{39} Meehan S. Medical College Admission Test is expanding its scope: social sciences added to mix. \textit{USA Today.} 28 March 2012:5D. Print.
\textsuperscript{40} Ibid.
trajectory of the medicalization of IPV in the United States healthcare system.

(I) JUSTICE STAGE:

Justice = “Wife Beating” (“Wife Battering”/Spouse Abuse)

From a private event to a social construct: People have grappled with how best to deal with violence and abuse between intimate partners for many years. For example, 1 Peter 3:7 of the Bible states, “Likewise, husbands, live with your wives in an understanding way, showing honor to the woman as the weaker vessel, since they are heirs with you of the grace of life, so that your prayers may not be hindered”\(^{41}\). For many years, statements like this one about how men should treat their wives contained messages that communicated an inherent power imbalance in marriage relationships. In particular, physical power was referenced to commonly as a primary source of males’ dominance over their wives. These social constructions of gender characteristics in intimate partner relationships shaped how people perceived IPV. In fact, on December 6, 1904, President Theodore Roosevelt

shared the following message about “wife-beating” in his State of the Union Address\textsuperscript{42}:

\textit{There are certain offenders, whose criminality takes the shape of brutality and cruelty towards the weak, who need a special type of punishment. The wife-beater, for example, is inadequately punished by imprisonment; for imprisonment may often mean nothing to him, while it may cause hunger and want to the wife and children who have been the victims of his brutality. Probably some form of corporal punishment would be the most adequate way of meeting this kind of crime.}

As a statement to the nation, President Roosevelt’s words portray mainstream cultural views at the time: males were viewed as physically dominant to females, and wives were viewed as dependent upon their husbands. The terminology used for IPV during this Justice Stage is telling: (1) “Wife beating” is a gerund that emphasized the perpetrator’s actions in abusing his wife; and, (2) only married heterosexual couples were recognized formally as intimate partner relationships within which violence and abuse occurred.

Soon thereafter, on February 3, 1905, \textit{The New York Times} published an article entitled “WOULD LASH WIFE

BEATERS. Representative Adams Pleads for His Corporal Punishment Bill” that included the following journalism:

“The bill provides that in the case of any person in this District who shall beat, bruise, or mutilate his wife the court before whom the offender is tried and convicted shall direct the infliction of a whipping on his bare back. The punishment, which is not to exceed thirty lashes, is to be inflicted by the Marshal of the District or one of his deputies, within the prison inclosure, and in the presence of a physician.” Interestingly, these lines reveal that physicians served in secondary roles in the management of IPV at the time; law enforcement officials were assumed to be the main agents in administering justice. However, Representative Adams’ suggestions foreshadowed future roles for physicians to play in responding to IPV as part of their professional responsibilities in society. Moreover, this article also captured IPV dynamics that are still at play today, such as victims fearing repeat violence and abuse by their perpetrators following disclosure:

"Mr. Adams explained that he lately studied this problem thoroughly, and he was convinced that the establishment of the
whipping post for wife-beaters would go far to prevent that crime. The charge of wife-battering often resulted in the sending of the man’s wife to the alms-house. Very often the wife hesitated to make the charge that her husband had maltreated her, because when the brute got out of jail he usually beat her again worse than before.

Adams’ assessment shows that focused efforts to investigate IPV and understand its underpinnings were already ongoing over a century ago. At that time, criminal penalties were the envisioned modes for preventing and controlling IPV in society; harsher penalties administered to perpetrators would deter IPV reoccurrence was the reasoning. In addition, inadequate responses by the justice system carried negative ramifications for females, leading to hesitation to disclose, which continues to be a key concern today when considering IPV response by law enforcement officers. Finally, Representative Adams concluded his advocacy by stating that “[e]very married man in the House who does not vote for this bill when it comes up lays himself open to suspicion,” conveying the strong emotional responses that IPV stirs up in

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people, which speaks to the moral and the ethical nature of this perplexing social problem.

Other governmental officials serving at the turn of the twentieth century also debated how best to approach IPV as a unique criminal justice issue. In 1906, as documented in the United States House of Representative’s Report No. 1057, the Board of Commissioners of the District of Columbia weighed the punishment options for men who beat their wives; and, Henry B.F. MacFarland, President of the Board, recommended “favorable action upon H.R. bill 8133, Fifty-ninth Congress, first session, ‘To provide for the infliction of corporal punishment upon all male persons convicted of willfully beating their wives [...]’”46. This support for a proposed criminal justice intervention to punish men who abused their wives indicates that people at the time perceived violence between intimate partners as different than violence between non-intimate partners47. Prior to this legislation consideration, in 1905, according to Judge I.G. Kimball of the police court of the District of Columbia, “[t]he offense of wife beating in the District of Columbia [was] charged under the general head of assault without any

46 Punishment for Wife Beating. Washington: [s.n.], 1906.
distinction as to whether the assault is made upon the wife or upon any other person”\textsuperscript{48}. However, after the Senate required the District of Columbia to count and report the number of instances of “wife beating” that took place (those that were actually reported to police authorities) from 1900 to 1905, the Board of Commissioners moved to distinguish “wife beating” from other forms of violence in terms of punishment. Thus, society first perceived IPV as a unique private interpersonal issue between a man and his wife. Early on in the twentieth century, this private affair challenged society because perpetrators’ actions ran counter to the normal behaviors that were stereotypically associated with intimate partner interactions—how best to deal with IPV remained unclear and was debated passionately by public leaders.

Over the decades that followed, people continued to wrestle with this uncertainty and, eventually, re-characterized IPV as a broader social issue. In fact, according to Gordon\textsuperscript{49}, the feminism movement transformed “wife beating” from a private affair into a social construct: “Defining wife-beating as a social problem, not merely a phenomenon of particular violent individuals or relationships, was one of the great

\textsuperscript{48} Letter From the President of the Board of Commissioners of the District of Columbia Transmitting, In Response to a Senate Resolution of January 24, 1905, a Statement of the Number of Convictions for Wife Beating In the District of Columbia Since 1900. Washington: [s.n.], 1905.

achievements of feminism. Women always resisted battering, but in the last hundred years they began to resist it politically and ideologically, with considerable success.” By exposing the social nature of IPV, the feminism movement started in motion a process that has continued to today: examination of the multi-factorial, ever-evolving nature of IPV. Writing in 1988 about the history of family violence leading up to the 1960s, Gordon posits that gender inequality made IPV a social issue: “[I]t is male dominance that makes wife-beating a social rather than a personal problem. Wife-beating is not comparable to a drunken barroom assault or the hysterical attack of a jealous lover, which may be isolated incidents. Wife-beating is the chronic battering of a person of inferior power who for that reason cannot effectively resist.” This gender stereotype of intimate partner relationships persisted for decades and came to a head in 1945 in California when a husband murdered his wife but was not convicted because the Judge deemed the relevant statute as unconstitutional since it discriminated on the basis of gender. In this case, the law read: “Any husband who willfully inflicts upon his wife corporal injury resulting in a traumatic condition, and any person who willfully inflicts upon any child any cruel and

inhumane corporal punishments or injury resulting in a traumatic condition, is guilty of a felony, and upon conviction thereof shall be punished by imprisonment in the state prison for not more than 10 years or in the county jail for not more than 1 year”\textsuperscript{52,53}. In a poignant way, this Judge’s reading and interpretation of the law demonstrates the power of language: the era of referring to IPV as “wife beating” was crumbling; in the decades that followed, people started to rethink their conceptions of gender and their positions on various aspects of human rights\textsuperscript{54}.

During this era, this social issue fell under the auspices of the criminal justice system. Law enforcement and the legal system (including lawyers, judges, and child-protection agencies, among others) were charged with the task of trying to prevent, monitor, and respond to IPV cases. According to Schechter\textsuperscript{55}, “Although laws vary significantly from state to state, the battered women’s movement worked legislatively to see that wife beating was treated as a crime—a

\textsuperscript{54} Ibid.
social, not a private matter”\textsuperscript{56}. Nonetheless, law enforcement alone could not manage IPV effectively (or, at times, appropriately). In fact, in writing about the battered women’s movement, Schechter states, “At the beginning of the movement, battered women complained frequently that the police simply would not come when called. If they did come, they would refuse to arrest, saying: ‘There’s nothing we can do. It’s a family matter; go to Family Court tomorrow’”\textsuperscript{57}. Without assistance from law enforcement, abused women turned elsewhere. Further speaking to the unique nature of violence between intimate partners, Gordon shares that “[t]he child-protection agencies originally tried to avoid intervention between husbands and wives, but their clients, mainly mothers, virtually dragged the child protectors into wife-beating problems”\textsuperscript{58}. In time, “child protectors accepted the feminist interpretation of this domesticity, that women’s and children’s interests were closely connected […]”, that “damage to one was a damage to both”\textsuperscript{59}. The justice response to IPV unfolded from this interconnected history with child abuse awareness, response, and advocacy. Society embraced child abuse as a criminal justice issue worthy of


\textsuperscript{57} Ibid., 158.


\textsuperscript{59} Ibid., 252-253.
legal intervention before it examined abuse between intimate partners—that is: “women were defended within the defense of children”\(^\text{60}\). Notably, as this discussion will show, orthopaedic surgeons were aware of, advocated for, and responded to child abuse many years prior to publishing and communicating about, studying, and formalizing approaches to patient care for victims of IPV. This differential response historically to child abuse as compared to IPV highlights once again the distinct nature of IPV.

During the Justice Stage of the medicalization of IPV, imbalance of power was a major theme, but that started to change during the transition to the Public Health Stage. In the 1960s, the civil rights movement eroded imbalances of power in society\(^\text{61}\). The combination of the feminism and the civil rights movements’ forces changed the nature of IPV in American society forever by empowering females to make public stands against violence and abuse. Resources for victims of violence and abuse improved too during the 1960s and the 1970s as leaders of the battered women’s movement

\(^{60}\) Ibid., 252-253.
founded shelters. Summarizing this combinatorial social movement synergy well, Gordon reflects as follows:

While the first-wave women’s movement had asserted women’s rights to personal freedom even in marriage, it had not provided any organized, institutional means for poor women to secure and defend that right, a power which was necessary for women really to believe in their own entitlement. Until the revival of feminism and the establishment of battered-women’s shelters in the 1970s, wife-beating victims had three resources: their own individual strategies of resistance; the help of relatives, friends, and neighbors; and the intervention of child-welfare agencies. None was adequate to the task.

In responding to this unmet social services need for women, battered women’s shelters served as hubs for the battered women’s movement. The rise of shelters for IPV victims established the roots needed for the grassroots movement that ushered in the Public Health Stage of this IPV evolution.

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story. For instance, *La Casa de Las Madres*, the first battered women’s shelter for women of color, was established in San Francisco, California in 1976, and it provided a physical space for the feminism and the civil rights movements to join forces synergistically to advocate for victims of discrimination and power imbalances in society\(^{65}\).

(I) **JUSTICE STAGE - Tripartite Medicalization of IPV**

**Summary:**

- Terminology: “Wife Beating/Battering” (In 1977, the United States National Library of Medicine introduced “Spouse Abuse” as a MeSH (Medical Subject Headings) term for PubMed indexing and defined it as follows: “Deliberate severe and repeated injury to one domestic partner by the other.”\(^{66}\)); “wife beating” was culturally situated and emphasized the role of the batterer’s criminal behavior during a time when heterosexual marriage was perceived to be the normal relationship for intimate partners.

- Legal Problem: Perpetrator’s criminal behavior; battery; assault.

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• Responders: Law enforcement; legal system (lawyers, judges/regulators, public officials).

• Recognition: Police decision at site of 911 call / incident; legal/judicial processes.

• Response: Penalize the perpetrator (corporal punishment, as one example).

• Prevention / Control: Extent of and enforcement of penalties administered to perpetrators; laws and regulations; training of law enforcement officers, of lawyers, of judges, etc.

(II) PUBLIC HEALTH STAGE:
Justice + Public Health = “Domestic Violence”

*Making sense of MeSH:* The United States National Library of Medicine (NLM) uses MeSH (Medical Subject Headings) terminology to organize publications in a logical manner. Officially, “MeSH (Medical Subject Headings) is the NLM controlled vocabulary thesaurus used for indexing articles for PubMed”67. Interestingly, the terminology logic tree for the term “Domestic Violence” looks like this (note: categories to the right of symbol “>>>” are embedded within all the categories in the tree that preceded them to the left of

symbol “>>”): “All MeSH Categories >> Anthropology, Education, Sociology and Social Phenomena Category >> Social Sciences >> Criminology >> Crime >> Violence >> Domestic Violence”⁶⁸. In a rudimentary way, this simple MeSH term logic tree for “Domestic Violence” captures accurately the mathematical progression of the medicalization of IPV during this era of history: the Public Health stage—Step 1 in the medicalization of IPV—evolved iteratively by adding to and embedding itself within the previous Justice stage. Consequently, components of and characteristics of the private interpersonal and the social construct histories of IPV bled through during the Public Health stage and continued to play active roles in directing IPV awareness, response, and advocacy in healthcare systems and in society.

**Historical scope:** The following Public Health stage history is not comprehensive; that task is beyond the scope of this essay⁶⁹. Overall, since the 1970s, many activists and numerous organizations have advocated for the advancement of the general perspective that *IPV is a social issue with important health implications and consequences and thus is a human condition that warrants appropriate recognition and response in healthcare settings.*

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⁶⁹ For a detailed timeline, please see: Herstory of Domestic Violence <https://people.uvawise.edu/pww8y/Supplement/-ConceptsSup/Gender/HerstoryDomV.html>. 
This view supports medicalization of IPV by recognizing the health effects of violence and abuse and by contending that HCPs are capable of responding to these health effects in ways that benefit IPV victims’ lives (their safety, health, and well-being, etc.). In short, this point-of-view drove Step 1 of the medicalization of IPV: the evolution of IPV from a justice issue to a public health issue. What follows, then, is a short discussion of some of those key agents of medicalization and the historical context amidst which they operated. An infectious disease model is applied to aid analysis with the goal of highlighting major themes.

*Context is everything:* Reframing IPV as a health issue is a significant jump in history; it transformed how society views IPV in many powerful ways. And, it is not by accident that this leap took place during the 1970s and 1980s. The cultural shifts that occurred during these decades created a new consciousness in society (some called it a “New Awareness”70): one that recognized and empowered victims. This new individualism appeared in many forms—racial equality, women's rights, gay rights, and disability rights, among others. Moreover, in the healthcare ecosystem, forces of medicalization blossomed, in part, out of a backlash against Health Maintenance Organizations (HMOs), which

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rose to prominence during this time in response to spiraling healthcare costs in a stagnant economy. Out of all this came a new focus on individuals as victims—these trends converged in the issue referred to during the Public Health stage as “Domestic Violence”71.

*The 1960s set the stage:* The activities of the 1960s established a platform for advocacy in the battered women’s movement. About this era, Anderson notes that “[t]he Sixties have seen the dawn of a new culture. The Seventies will see its flowering”—and this deft description applies to the battered women’s movement as well72. During the 1970s, by establishing battered women’s shelters, female activists and advocates for victims of violence and abuse started to pool their energy and resources together around these central hubs, building up the momentum needed to participate actively in the New Awareness era that the 1960s jumpstarted. These advocates for battered women questioned society’s limited and unsatisfactory Justice stage approach to IPV while participating in a broader process that involved people from all walks of life who questioned many ethical, moral, and professional values, assumptions, and beliefs promulgated by mainstream American culture at the time.

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71 Note: Conceptual framing of this period of history credited to communications with Nathaniel Comfort, The Johns Hopkins University, Department of The History of Medicine. Feb. 2013.
The slogan that eventually surfaced—“Break the silence on Domestic Violence”—captured this activist spirit of the battered women’s movement, which was kindred to the motivations held and expressed by various minority groups during “The Sixties”:

Ever since those turbulent times, Americans have been debating the era that began in 1960 at Greensboro and that ended in the early 1970s when Congress passed the Equal Rights Amendment and the U.S. Army came home from the Vietnam War. The long decade was an endless pageant of political and cultural protests, from sit-ins at lunch counters to gunfire at Wounded Knee. The irrepressible issues, the shocking events, forced citizens to consider disturbing questions—was America racist, imperialist, sexist? And the relentless demonstrations, the fires in the streets, forced neighbors to take a stand and decide publicly about policies concerning a legion of new topics—from civil rights to women’s liberation. America was opened to scrutiny. Nothing was sacred, everything was challenged, and the result was an era we simply call “The Sixties”.

In this way, the feminism and the civil rights movements propelled activists in the battered women’s movement to

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73 Ibid., xiii.
question power imbalances in society, providing the support needed to speak out publicly and make bold stands for IPV victims during the 1970s. In fact, when Del Martin (a co-founder of the *La Casa de Las Madres* battered women’s shelter in San Francisco) published *Battered Wives* in 1976, she harnessed this support to produce “a major source of information and validation for the movement. It [legitimized] the view that violence against women is caused by sexism”\(^{74}\). Furthermore, demonstrating how the gay rights and the battered women’s movement intertwined at this time, “[f]or many years, Del Martin was a leader in the campaign to persuade the American Psychiatric Association to declare that homosexuality was not a medical illness. This goal was finally achieved in 1973”\(^{75}\). As an activist, Martin called for de-medicalization of homosexuality; however, by helping society re-conceptualize “wife battering” as a health issue, she participated in Step 1 of the medicalization of IPV. Specifically, the influence of the gay rights movement on the terminology employed by members of the battered women’s movement is conveyed in Martin’s reflective writing in *Battered Wives*\(^{76}\):

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Throughout this book I have used the term “battered wives,” although most of what I have to say applies equally to unmarried women who live with violent men, and many of the examples cited involve unmarried cohabitants. I hesitate to call these women “common-law wives,” since many have chosen, for a variety of reasons, not to classify themselves as wives in any sense of this word. No adequate term seems to exist for the man in such a relationship either. “Lover” hardly seems appropriate. [...] The term “battered wife,” therefore, usually refers to any woman who is beaten by her mate, whether legally married or not, and the word “husband” applies to the man in the couple.

Martin’s discussion of language demonstrates that society continued to debate how best to label IPV at this time; it is evident, though, that Martin’s thoughts explore and open up the varying types of relationships within which intimate partner abuse could occur. At this point in history, the term “wife beating” no longer described IPV adequately.

The 1970s fueled the first wave. In Battered Wives, Martin writes: “Wife-beating [...] is a complex problem that involves much more than the act itself or the personal interaction between a husband and his wife. It has its roots in historical attitudes towards women, the institution of marriage, the economy, the intricacies of criminal and civil law, and the
delivery of social services agencies”\textsuperscript{77}. Speaking up for the battered women’s movement, this novel recognition of IPV as an issue with far-reaching implications that crossed all sectors of society re-conceptualized IPV, pushing its borders outward beyond the scope of the criminal justice system. According to Berkowitz, this type of shift in perspective and expansion of consciousness characterized the 1970s with regards to civil rights, disability rights, gay rights, and women’s rights in general\textsuperscript{78}:

\textit{The new civil-rights movements of the seventies involved more fundamental critiques of postwar society. Women sought to reorient gender relations. […] People with disabilities sought nothing less than the physical redesign of America to end the physical barriers that prevented them from full participation in American life. They emphasized that society, rather than the disabled themselves, needed to change. Gays argued that homosexuality not be viewed as a form of deviance that required psychiatric intervention but rather that it be accepted as a legitimate form of sexual orientation.}

\textsuperscript{77} Ibid., xiv.

Amidst this social movement climate, the idea that society needed to change proved critical to the medicalization of IPV as well; society needed to recognize and to respond to the negative health effects of violence and abuse in order to ensure that IPV victims could participate fully and safely in American life. While gay rights activists called for de-medicalization of sexual orientation, IPV advocates called for medicalization as they re-oriented IPV as a pressing public health concern.

**Contesting medicalization:** In the mid- to late-1970s, some HCPs embarked on a journey to improve response to and to raise awareness about the health consequences of IPV. As early agents for the medicalization of IPV, some nurses and physicians helped set up hospital-based domestic violence programs, while others began publishing articles about what they perceived as a serious public health problem that had persisted in society for far too long without appropriate solutions.

However, before diving into the specific steps of this evolution, it is valuable to step back and examine another process that was at play at this time: widespread medicalization of many aspects of life. This expansion in the scope of medical practice led some critics in the 1970s to

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question this extensive encroachment of healthcare interventions on people’s lives. For example, to this point, Illich stated: “The proliferation of medical agents is health-denying not only or primarily because of the specific functional or organic lesions produced by doctors, but because they produce dependence. And this dependence on professional intervention tends to impoverish the non-medical health-supporting and healing aspects of the social and physical environments …”80. When society expands the roles that HCPs play in caring for human conditions, dependency, at some level (it could be minimal, it could be extreme), sets in as patients come to rely on these healthcare services. Expecting HCPs to participate in screening for victims of abuse, for instance, starts this intervention-encroachment process in motion, (potentially) creating a slippery slope as the boundaries of medical practice blur into other aspects of society. Moreover, medicalization (potentially) carries an economically burdensome price tag as well, which tends to be a marginalized downside, as Illich points out, because “[…] people also still believe that health levels will improve with the amount spent on medical services, that more medical interventions would be better,

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and that doctors know best what these services should be.”

Ultimately, what Illich’s critiques bring to light is the need to question medicalization as it updates, in real time, to evaluate it as a process and to determine if its outcomes and effects are beneficial to patients individually and to society generally.

Ethically, medicalization—as a process, as evolution—is not beneficial or detrimental inherently. To be certain, it is impossible to predict perfectly a priori the long-term trajectory of medicalization in each case, but naming medicalization in straightforward terms for what it is—that is, making aspects of a human condition subject to interventions by the medical system and its HCPs—opens up discourse on the topic, engaging conversations that could help direct the trajectory of medicalization for the best. Though, to be sure, what is the “best” course varies from case to case along the spectrum of de-medicalization to medicalization, with different activists and organizations advocating for their determinations of how best to proceed.

A new definition of “health”: Weighing these considerations concerning the medicalization of IPV, soon

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81 Ibid., 73-75. Illich shares cost concerns and health policy issues that were prominent in the 1970s and are still applicable today as the size of the United States healthcare system continues to expand economically.

82 For a discussion on the medicalization of childbirth, for instance, please see: Johanson R, Newburn M, Macfarlane A. Has the medicalisation of childbirth gone too far? BMJ. 2002 Apr 13; 324(7342):892-5.
thereafter, Fox responded to Illich’s comments by highlighting the ways in which American society was embracing a broader view of “health” during the 1970s. For instance, Fox emphasized the following definitional underpinnings:

One indication of the scope that the ‘health-illness-medicine complex’ has acquired in American society is the diffuse definition of health that has increasingly come to be advocated: ‘a state of complete physical, mental, and social well-being,’ to borrow the World Health Organization’s phrase. This conception of health extends beyond biological and psychological phenomena relevant to the functioning, equilibrium, and fulfillment of individuals, to include social and cultural conditions of communal as well as personal import. Such an inclusive perspective on health is reflected in the range of difficulties that persons now bring to physicians for their consideration and help. [...] In turn, these developments are connected with higher expectations on the part of the public about what medicine ideally ought to be able to accomplish and to prevent.

As Fox indicates, as people’s conceptions of health broadened, the territory of public health expanded, and human conditions like IPV that were once beyond the scope

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of public health concern were brought into the medical fold, establishing new expectations of physicians and surgeons and of other HCPs to respond appropriately in their redefined, updated roles. Fox clarified, though, that this pattern of “sin-to-crime-to-sickness evolution” is not unique to IPV (it played out in America with the “battered child syndrome” as well); it is a type of “medicalization of deviance” that “has been a general tendency in society to move from sin to crime to sickness in categorizing a number of aberrant or deviant states”.

During the Justice stage of the history of the medicalization of IPV, society focused on responding to the criminal behaviors of perpetrators as its primary intervention strategy. During Step 1 of the medicalization of IPV, as IPV morphed into a public health issue, IPV victims’ suffering gained prominence as women like Del Martin spoke out against abuse to share with and expose to the world its widespread consequences. Finally, Fox defined “illness” as “deviance from the desirable and the normal,” and, as the view of what constituted health changed during the 1970s, the public health model gained applicability: victims of violence and abuse by intimate partners experienced unfortunate and traumatic states of affairs that adversely affected their health and well-being physically, mentally, and emotionally. In this way, IPV was an “illness” because

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84 Ibid., 11.
patients who were victims of violence and abuse suffered from a “deviance from the desirable and the normal”—patients in unjust, abusive relationships were not experiencing desirable or normal lives.

*Agents for medicalization:* Applying this new consciousness of health to healthcare, HCPs started questioning how healthcare systems recognized and responded to IPV victims as patients. To start, in 1977, Parker and Schumacher published “The battered wife syndrome and violence in the nuclear family of origin: a controlled pilot study” in the *American Journal of Public Health*, establishing the first nursing research article on IPV.\(^85\) Notably, the title of this article included the word “syndrome,” a term that captured formally the re-framing of IPV medically. In their paper, Parker and Schumacher defined the “Battered Wife Syndrome (BWS)” as “a symptom complex of violence in which a woman has, at any time, received deliberate, severe, and repeated (more than three times) demonstrable injury from her husband, with the minimal injury of severe bruising.”\(^86\) Technically, a syndrome is a constellation of signs and symptoms “that often occur together, so that the presence of one or more features alerts

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\(^86\) Ibid., 760.
the healthcare provider to the possible presence of the others”\textsuperscript{87}. For instance, in the emergency room setting, “BWS” could present as facial bruising coupled with emotional trauma (Post-Traumatic Stress Disorder) and chronic low back pain, as one possible clinical presentation constellation. An emergency medicine physician informed about this syndrome could include it on her differential diagnosis and could respond appropriately by inquiring about abuse and then counseling the patient about available resources in the local community. In this hypothetical scenario, the existence of “BWS” as a real medical entity aided identification and response in a healthcare setting; thus, it supported the public health model for screening and intervening. In their study, Parker and Schumacher surveyed 50 women and found that “[i]f the mother in the wife’s family of origin was a victim of the BWS, there was a statistically significant probability that the wife would be battered by her husband”\textsuperscript{88}. In a concrete manner, this type of epidemiological research signaled the start of the Public Health stage of the history of the medicalization of IPV.

Furthermore, the “Discussion and Implications” section of this article framed the new public health role that


physicians were now expected to play as IPV responders and advocates:

Health care practitioners should be alert to wife-beating and its sequelae in interviews, histories, and physical examinations. For example, one of the 20 battered women in this study suffered hemiparesis five days after severe head trauma; her treatment and follow-up included no attention to the apparent etiology of her morbidity. Therapeutically, primary practitioners need to develop mechanisms to break the cycle of spousal violence and its transmission. While this study focused on the working class, the Battered Wife Syndrome spares no socioeconomic class.

Analyzing the language that Parker and Schumacher elected to use is revealing: (1) Use of the word “therapeutically” assigned physicians with the task of “treating” BWS; it assumed (accurately or inaccurately) that physicians were capable of intervening in ways that benefitted IPV victim patients’ health states; and, (2) use of the word “transmission” implied that BWS was some type of “disease” that was “infecting” members of society with detrimental health consequences. Thus, Parker and Schumacher

89 Ibid., 761.
established an infectious disease model framework for viewing IPV as an emerging public health problem. Perhaps, in this framework, if BWS represented the “disease,” then IPV perpetrators were the “disease vectors”; and, their ‘power and control’\textsuperscript{90,91} abusive behaviors were “infecting” IPV victims’ lives (as well as their minds, their bodies, and, perhaps, even their souls). If so, then, as cultural and socioeconomic forces combined to breed more and more perpetrators, BWS “transmission” in society proliferated, leading to a BWS “epidemic”—an outbreak. At this point, with a medical term applied to IPV for diagnosis published, with a call for treatment by primary care physicians sounded, and with recognition of illness transmission identified, Step 1 of the medicalization of IPV established a strong foothold for further Public Health stage footsteps.

Nevertheless, as expected given the history and the nature of this complex social issue, early responses showed that aspects of the Justice stage continued to bleed through and shape the Public Health stage. For instance, in response to Parker and Schumacher, in the same issue of the \textit{American Journal of Public Health}, Friedman highlighted the legal side of


IPV response about which physicians should be knowledgeable: “Health practitioners should know the law affects their actions and how to safeguard themselves. Education at all levels of the health profession is needed. […] Health practitioners need to know what protection the law can provide a victim; how the legal process works; and procedures for coordinating with legal assistance, therapeutic counseling, and community service resources”92. In addition, further revealing the infectious disease characterization of IPV at the time, Friedman communicated the public health response of prevention / protection through referrals to community resources like battered women’s shelters (akin to “quarantines”): “Referrals are a vital part of preventing recurrence of the injuries since women need reassurance from professionals that they are victims of a crime, that others suffer similar abuse, that they do not have to tolerate it, and that they can get protection”93. She also compared IPV to child abuse in calling for medical intervention: “Like child abuse, it is an issue which demands social, legal, and medical intervention. […] While medical personnel treat the injuries, they ignore the cause. They treat the symptoms; not the illness. […] The health profession has a powerful influence on the welfare of the citizenry. One need only to contemplate

93 Ibid.
the proliferation of legislation, social services, and medical care to treat child abuse, generated by the medical profession”\textsuperscript{94}. From this vantage point, the medicalization of child abuse was perceived as a net benefit to society and as an interdisciplinary response clinically. Freidman’s words also implied that viewing BWS as an illness—employing Fox’s definition of “illness” as “deviance from the desirable and the normal”—was an important step: HCPs needed to look beyond the symptoms of BWS; they needed to inquire about the etiology of injuries: they needed to diagnose BWS accurately so that they could intervene in ways that restored, preserved, or improved victims’ health states. And, they needed to know the legal ramifications of their acts.

As next steps, more and more healthcare leaders explored BWS further from a public health perspective. For example, in 1979, Stark et al. examined how victims of abuse interface with the healthcare system (with the objective “to describe the pattern of abuse associated with battering and to evaluate the contribution of the medical system and of broader social forces to its emergence”) and published “Medicine and patriarchal violence: the social construction of a ‘private’ event” in the *International Journal of Health Services*\textsuperscript{95}. In this pilot study of 481 female patients using emergency

\textsuperscript{94} Ibid.

\textsuperscript{95} Stark E, Flitcraft A, Frazier W. Medicine and patriarchal violence: the social construction of a "private" event. Int J Health Serv. 1979;9(3):461-93.
services, Stark et al. found, among other things, that, “At first, the physical trauma associated with abuse is medicated symptomatically. But the patient's persistence, the failure of the cure, and the incongruity between her problems and available medical explanations lead the provider to label the abused woman in ways that suggest she is personally responsible for her victimization”\textsuperscript{96}. This finding indicated that if physicians caring for IPV victim patients ignored the etiology of the abuse-related injuries and their health effects then these patients subsequently blamed themselves, leading to an undesirable outcome, not to a healing process: it is as if IPV were the elephant in the emergency room. Once this IPV elephant was named and its presence ascertained, an academic, research-based approach to understanding the intersection of violence and health unfolded. For instance, Walker added to these early works as she outlined the concept of “The Battered Woman Syndrome”\textsuperscript{97} by testing the “Walker Cycle Theory of Violence”\textsuperscript{98} in a research study intended to elucidate the psychology of IPV. Walker observed “learned helplessness” in BWS, so she postulated a “tension-reduction theory that states that there are three distinct phases associated with a recurring battering cycle: (1) 

\textsuperscript{96} Ibid.
tension-building, (2) the acute battering incident, and (3) loving-contrition”\textsuperscript{99}. The results of this investigation (which interviewed battered women, asking them for detailed, open-ended descriptions about four battering incidents (the first, the second, one of the worst, and the last), followed by close-ended questions about the batterer’s behavior\textsuperscript{100}) were published in 1980 and did not refute this hypothesis about the cyclical nature of BWS: “It is clear, however, that our data support the existence of the Walker Cycle Theory of Violence. Further, over the course of a battering relationship, tension building before battering becomes more common (or evident) and loving contrition declines. Thus, results strongly suggest further investigations into the psychological costs and rewards in these relationships”\textsuperscript{101}. Shaping the medicalization of IPV story academically, this conclusion calling for more research on the mental health dynamics of IPV solidified the dawn of an evidence-based public health approach to this newly framed health issue.

Interestingly, in 2000, reflecting back on her 1980 publication, Walker framed the Public Health stage of the medicalization of IPV using an infectious disease analogy\textsuperscript{102}:

\textsuperscript{99} Ibid.
\textsuperscript{100} Ibid., 127
\textsuperscript{101} Ibid., 128.
\textsuperscript{102} Ibid., 15.
It is interesting that we reported the findings from this study as risk factors long before the recent categorization of family violence in similar terms. Once it was established that family violence and violence against women was at epidemic proportions by U.S. Surgeon General C. Everett Koop (1985), violence began to be conceptualized as a public health problem that would be best understood through epidemiological community standards. Planning intervention and prevention programs use the criteria of risk and resiliency factors rather than thinking in more pathology terms of illness and cure.

One of the most interesting analogies comes from the public health initiative to eradicate malaria. It was found that people would be less likely to become sick from malaria if they were given quinine as a preventive measure. So, strengthening the potential victims by prescribing quinine tablets was an important way to keep safe those who could not stay out of the malaria-infested area. Once it was learned that diseased mosquitoes carried the malaria germ, it became possible to kill the mosquito. However, unless the swamps that bred the malaria germs that infected the mosquito were drained and cleaned up, all the work in strengthening the host and killing the germ-carrier, would not have eliminated malaria—it will return!
So, too for domestic violence. We can strengthen girls and women so they are more resistant to the effects of the abusive behavior directed toward them and we can change the attitudes of known batterers so they stop beating women. However, unless we also change the social conditions that breed, facilitate and maintain all forms of violence against women, we will not eradicate domestic and other violence—it will return!

Our data support the demand for a war against violence inside and outside of the home.

From an infectious disease perspective, Walker’s use of a malaria analogy and her call for a “war against” IPV further support the notion that, during Step 1 of the medicalization of IPV, BWS was constructed as if it were an infectious disease: (1) ‘power and control’ represented the pathogen being transmitted throughout society, creating an epidemic; (2) perpetrators (as disease vectors) infected victims via violent and abusive behaviors; (3) cultural and socioeconomic forces—the disease vectors’ environments—bred more perpetrators; and, (4) traditional public health interventions intended to eradicate BWS were identified: (a) induce “resistance” in females using methods (akin to vaccines) that
“strengthen” them against abusive behavior; (b) treat/cure the disease therapeutically using modalities that “change the attitudes of known batterers so they stop beating women”; and, (c) wage a “war against violence” so that it does not recur (similar to how public health officials have worked to eliminate other infectious diseases like polio and malaria). Notably, this notion of a public health “war” was a theme in post-World War II America, characterizing the “breast cancer wars” that played out in the decades leading up to the 1980s\(^\text{103}\).

Meanwhile, leading the advocacy charge ahead of and in parallel to these early public health inquiries and theories, the battered women’s movement continued to emerge and gain momentum amongst the lay public in the United States. This burgeoning movement grew—in part, as one of the strongest geographical foci—out of the grassroots of San Francisco, California. San Francisco provided a centralized location for the confluence of forces at play in the women’s rights, civil rights, gay rights, disability rights, and battered women’s movements to interplay synergistically. San Francisco is where Martin’s publisher, Volcano Press, was

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located, led by Ruth Gottstein\textsuperscript{104}. San Francisco is also where battered women’s shelters flourished, such as the one that Martin co-founded in 1976, \textit{La Casa de Las Madres} (“California’s first and the nation’s second shelter dedicated to women and children escaping domestic violence”)\textsuperscript{105}. And, San Francisco is where, in 1980, Soler founded the Family Violence Prevention Fund (now Futures Without Violence), creating an organization that has served as one of the world’s leading advocates for IPV issues in healthcare for more than thirty years\textsuperscript{106}. Today, Futures Without Violence communicates its mission in a way that captures the modern tripartite conception of IPV\textsuperscript{107}:

\textit{We advance the health, stability, education, and security of women and girls, men and boys worldwide. In 1994, Futures Without Violence was instrumental in developing the landmark Violence Against Women Act passed by the US Congress. Striving to reach new audiences and transform social norms, we train professionals such as doctors, nurses, athletic coaches, and judges on improving responses to violence and}

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\textsuperscript{104} Read Ruth’s story about her idea to publish Del Martin’s ground breaking book here: Accessed on 13 March 2013 \<http://www.volcanopress.com/pages/catalog.cgi?mrchcatid=4&mrchid=54>. \\
\textsuperscript{105} Our Story. La Casa de Las Madres. 2013. Accessed on 13 March 2013 \<http://www.lacasa.org/our-story/>. \\
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abuse. As well, we work with advocates, policy makers and others to build sustainable community leadership and educate people everywhere about the importance of respect and healthy relationships – the relationships that all individuals, families, and communities need and deserve.

This statement illustrates the prominent historical role that Futures Without Violence has played in shaping the trajectory of the medicalization of IPV: by advocating for a new understanding of IPV as a social issue with real and important health effects that should be addressed in healthcare settings, this organization and its leaders have served as agents for medicalization for over thirty years. This statement also emphasizes an interdisciplinary nature to IPV awareness, response, and advocacy, citing educational outreach that spans the justice, public health, and medical systems.

Also in 1980, another one of the most prominent geographical foci of the battered women’s movement cropped up in Minnesota. The Duluth Abuse Intervention Program (DAIP) “began in 1980 as an initiative to reform the criminal justice system in Duluth, Minnesota. At that time, victims of domestic violence had little recourse when being 

assaulted by their intimate partners. Perpetrators were rarely arrested unless the assault happened in front of an officer or the injuries sustained by the victim were serious. Choices for victims were limited—initiate criminal justice charges, endure the abuse or flee the relationship”\(^\text{109}\). Today, as it has since its inception in 1980, the Duluth Model approaches IPV in the following manner: (1) it removes blame from the victim and places accountability for the abuse on the perpetrator; (2) it engages battered women in the policy-creation process to reform the criminal and civil justice systems to reflect this focus to hold offenders accountable; and, (3) it “works to change societal conditions that support men’s use of tactics of power and control over women,” including offering “opportunities for offenders through court-ordered educational groups for batterers”\(^\text{110}\). In effect, the Duluth Model started as an intervention to eradicate IPV from its community by altering the “societal conditions” that bred perpetrators (disease vectors); it hybridized justice and public health approaches to managing IPV, representing the Public Health stage of the medicalization of IPV classically. Since its small-scale, local beginnings, the Duluth Model’s reach has


expanded tremendously and has influenced other organizations and IPV advocates throughout the world, serving, like Futures Without Violence, as an agent for the medicalization of IPV.

The first wave crashes to shore: By 1985-86, the first major wave of the battered women’s movement crashed to shore. Firstly, further demonstrating the interdisciplinary nature of this patient advocacy movement, Campbell created the “Danger Assessment” screening instrument for HCPs to use to assess patients’ homicide risk when treating victims of abuse in clinical settings. Campbell developed this instrument out of necessity while working as a nurse, caring regularly for patients who were victims of violence and abuse. She recognized a need for resources for HCPs to serve in their roles as caregivers and advocates for these patients, so she “created the first Danger Assessment (DA) to help victims of abuse and the professionals who work with them to better understand the threats to their safety and well-being.” This clinical tool continues to be used widely in practice today, and it includes a calendar (“to raise the consciousness of the woman and reduce the denial and

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minimization of the abuse, especially since using a calendar increases accurate recall in other situations”) and a 20-item score instrument (that “uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide”)\textsuperscript{113}. As a general screening tool that clinicians could use in any healthcare setting—from emergency room to orthopaedic outpatient office—Campbell’s Danger Assessment instrument symbolizes the generalized Public Health stage screening approach; it empowered HCPs of all types with an evidence-based resource that they could use to provide patient care for victims of abuse. Secondly, by 1985, the battered women’s movement had gained enough momentum for the Surgeon General, C. Everett Koop, to publish a special report on domestic violence, “Domestic Violence and Public Health,” demarcating this social issue as a mainstream public health problem that HCPs were expected to play active roles in solving\textsuperscript{114}. To produce this report, Koop organized a workshop that brought together over 150 experts on topics at the intersection of violence and health, and Flitcraft reported on prevention of spouse abuse, which now was referred to

commonly as “Domestic Violence.” In a straightforward manner, Koop stated cogently that advocating for victims of violence and abuse was one of HCPs’ responsibilities: “Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professions have deferred to the criminal justice system. …[Today] the professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue”\textsuperscript{115}. In 1993, reflecting back on Koop’s domestic violence leadership, Flitcraft composed a commentary that summarized the Public Health stage of the medicalization of IPV\textsuperscript{116}.

\textit{In 1985 Surgeon General C. Everett Koop convened an unprecedented workshop on violence and public health. This conference which focused on the use of traditional public health tools to understand violence in epidemiological terms, marked a turning point in public health officials’ involvement in domestic violence. Shelters for battered women had sprung up around the country during the 1970s, focusing the awareness of lawmakers, service providers, and researchers on the problems of women victimized by domestic violence. Not until this historic meeting, however, did an}


\textsuperscript{116} Ibid., 154.
articulated strategy emerge to address violence as a public health problem. This strategy encompassed prevention and intervention tools, which then were disseminated to the public health community through regional conferences. A newly created National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention (CDC) quickly expanded its emphasis on deliberate interpersonal injury to provide leadership and support for research on a wide range of issues, including domestic violence.

In historical terms, this publication by Flitcraft in 1993 in Health Affairs entitled “Physicians And Domestic Violence: Challenges for Prevention” bridged the Public Health stage of the medicalization of IPV to the current Clinical Medicine stage; the era of asking physicians to play a public health role in IPV screening and response proved ineffective, prompting Flitcraft to call for another era in the evolution of IPV awareness, response, and advocacy in medical settings\textsuperscript{117}:

\textit{[O]nly a small portion of what happens in the physician/patient encounter is determined by individual physicians. The encounter is shaped by its social and cultural context, the policies and resources of health care institutions, and the beliefs, values, and professional norms of the medical community. It is naïve to expect substantial

\textsuperscript{117} Ibid., 156
changes in how victims of domestic violence are now treated by individual physicians unless there are concurrent changes in these latter areas. [...] I suggest that change is required at each of these levels—clinical practice, institutional resources, and professional norms—to link the prevention of domestic violence with appropriate care for its victims. That is, I suggest a way for physicians to recognize domestic violence as their issue. [emphasis added]

With these choice words, Flitcraft suggested a Clinical Medicine stage for the medicalization of IPV where physicians participated actively in carving out their new roles in society as IPV victim patient advocates. The battered women’s movement had raised social awareness about IPV; a diverse collision of cultural forces had transformed IPV into a public health issue, building a wave of momentum and a sea of change; but, the net result of this wave crashing to shore was casting physicians into roles that they were not adequately trained to play. The first wave of the battered women’s movement swept up HCPs, and knowledge gaps were unearthed when the tide rolled out. However, as this story will show in the Clinical Medicine stage, in response to this new responsibility, physicians realized that they could contribute beneficially to public health most effectively by
embracing the medical context and clinical nuances of IPV as it presents in their specialty-specific settings. Therefore, Flitcraft’s message outlined the future of specialty-specific awareness, response, and advocacy for IPV; in short, “Clearly, another role for physicians [was] needed”\textsuperscript{118}.

In reality, the Public Health stage and the Clinical Medicine stage of the medicalization of IPV overlapped substantially, with the former bleeding through into the latter; however, Flitcraft’s assessment provides a historically accurate and an educationally informative transition point in this story.

(II) PUBLIC HEALTH STAGE –
Tripartite Medicalization of IPV

Summary:

- Terminology: “Battered Wife/Woman Syndrome (BWS)” initially; eventually replaced by “Domestic Violence” (In 1994, the National Library of Medicine introduced “Domestic Violence” as a MeSH term for PubMed indexing and defined it as follows: “Deliberate, often repetitive, physical abuse by one family member against another: marital partners, parents, children, siblings, or any other member of a

\textsuperscript{118} Ibid., 160.
household”119); and, public health language of a “war on violence” and the domestic violence "epidemic" (as in Surgeon General Koop’s report120, for example) characterized this stage as the focus transitioned to the victims of abuse and to their health states as patients—an associated epidemic of victims emerged in the United States.

- Disease / Illness / Syndrome (a focus of this stage): Perpetrator’s ‘power and control’ over victim (socioeconomic manifestations, for instance) was the pathogen of BWS; also, domestic violence as a primary social construct with secondary general health effects (sexual health, traumatic injuries, and psychological impact emphasized early on).

- Disease Vectors: Perpetrators / batterers (virulence of the virus-like disease was shaped by social/cultural environment).

- Responders (agents for medicalization): HCPs like social workers, psychologists, nurses, and physicians (primary care doctors, primarily); battered women’s


movement activists and organizations like Futures Without Violence and The Duluth Model.

- **Signs and Symptoms:** Physical, mental, and emotional manifestations of abuse, including sexual coercion and a general inability to lead a safe, productive lifestyle free of fear; Fox’s definition of “illness” as deviance from the desired and the normal; and, Walker’s “Learned Helplessness” concept and the associated cycle of violence in BWS.

- **Transmission:** Socioeconomic forces, cultural forces, and abusive environments breed perpetrators (as the disease vectors).

- **Diagnosis:** General screening tools (Campbell’s Danger Assessment\(^{121}\), for instance).

- **Treatment:** HCPs identify victims and refer them to community resources (battered women’s shelters); justice system response bleeds through in The Duluth Model.

- **Prevention (a focus of this stage):** Help victims escape violent environments (akin to quarantining); engage HCPs in efforts to identify IPV patient cases and then to refer these victims to appropriate community resources where they can receive support (akin to

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administering vaccines that strengthen immunity); and, enroll batterers in counseling programs (as a therapeutic intervention, like a drug to treat/cure the disease.)

(III) CLINICAL MEDICINE STAGE:
Justice + Public Health + Clinical Medicine = “IPV”

As Flitcraft envisioned, various healthcare organizations and specialties of medicine started focusing in and working on IPV in their specific domains: Step 2 of the medicalization of IPV. For instance, leading the charge among specialists, in 1989, the American College of Obstetricians and Gynecologists (ACOG) self-assembled and published “The battered woman” to discuss care for victims of violence and abuse. Setting the stage, the year prior, in 1988, Chez published “Women Battering” in the American Journal of Obstetrics and Gynecology, establishing the first OB/GYN journal article on IPV. Then, in 1992, the American Medical Association (AMA) composed diagnostic and treatment guidelines for physicians and surgeons to use

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when caring for domestic violence victims as patients. These general protocols served as an organized response by the AMA to recognize the health effects of abuse formally and to contribute actively to shaping physicians’ roles and clinical practices in caring for victims as patients. In a similar spirit, also in 1992, the American Nurses Association (ANA) published its first position statement on “physical violence against women,” further demonstrating the interdisciplinary nature of this clinical movement to direct the trajectory of the medicalization of IPV most optimally. Soon thereafter, in 1993, the National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention (CDC) organized the Family and Intimate Partner Violence Prevention Team to assess the scope of this problem in the United States healthcare system and then offer community solutions based on scientific research, illustrating how public health dynamics have bled through into the Clinical Medicine stage. In this same year, the first article relevant to IPV in clinical orthopaedics appeared in the nursing literature when Varvaro and Lasko published

“Physical abuse as cause of injury in women: information for orthopaedic nurses” in *Orthopaedic Nursing*\(^{128}\). Together, these organizational and academic efforts served as early “forces of conversation” that fueled communications during Step 2 in the medicalization of IPV into a clinical medicine issue. As this history will show, “forces of silence” cropped up as well during the evolution of this Clinical Medicine stage as some physicians and surgeons contested the further medicalization of IPV in their specialties.

*The second wave of the battered women’s movement crashes to shore*: It is often the case with social issues that media attention from celebrity events shines light on problems that were previously neglected or were out of the public eye. In fact, historians of medicine observe that “[t]he process by which emerging illnesses move from individual conditions to public health issues is shaped at all stages by how the illnesses are covered by the media”\(^{129}\). This occurred during the mid-1990s for domestic violence, a time when aspects of the Public Health stage hemorrhaged through into the early beginnings of the Clinical Medicine stage. In 1995, California passed legislation (bill AB 890) that set a new precedent in medicine by making California the first state in the United


States to require HCPs in hospitals and in clinics to screen for and report domestic violence\textsuperscript{130,131}. Raising awareness right away, this mandate engaged HCPs in the care of victims of violence and abuse in a drastically different way because now they had no choice: they had to respond to IPV victims and had to report their cases to the State of California in order to comply with the law—the Justice stage of the medicalization of IPV was at play. At this point, physicians and surgeons now carried clear (1) legal, (2) public health, and (3) medical responsibilities and duties in caring for IPV victim patients—the tripartite nature of the Clinical Medicine stage of the medicalization of IPV was here to stay, codified in California by state law, for better or for worse. During this same time, the O.J. Simpson murder trial and its associated media attention increased awareness for domestic violence around the world like never before, spurring further evaluation of this issue in healthcare\textsuperscript{132}. Nicole Brown Simpson’s tragic death forced people from all walks of life to reflect more deeply about IPV and its implications for society. This celebrity IPV case demarcated the peak of the second wave of the battered women’s movement. Historians identify this type of peak resulting from the celebrity statuses of the people

\textsuperscript{132} James, Lisa. Personal interview. 24 July 2012.
involved in the case as a recurring emergence pattern in medicine, noting that, “[i]n general, the visibility of an emerging illness is very much dependent on whom the disease affects”\textsuperscript{133}. Notably, this same phenomenon played out also in the emergence stories of the AIDS and the patients’ right movements\textsuperscript{134,135}. Reflecting on this dynamic, McCue offered the following observation in writing her book, \textit{Domestic Violence: a Reference Handbook}\textsuperscript{136}:

\textit{The problem of domestic violence is very old, but public acknowledgement of the issue as a societal problem is still in its infancy. A thread I found running through all of the research of all societies was that which I call the “curtain of silence.” Occasionally, a case involving domestic violence becomes a media event. And for a while, as happened after the O.J. Simpson case in the 1990s, public figures give the issue their attention and a small amount of progress is made. But when the interest dies down, the curtain comes down and domestic violence is once again relegated to a place where the issue is discussed only by professionals, advocates, and...}

activists. Many people throughout the world look at domestic violence as a private family matter that should be dealt with in private. What we know is that although it happens behind closed doors, it is very much a public issue that affects all of society.

McCue’s “curtain of silence” concept for IPV awareness, response, and advocacy speaks to the “forces of silence” versus “forces of conversation” nature of communication about this issue that has flowed—as the curtain goes up and down—throughout its history: when “forces of conversation” accumulated and gathered a critical mass of momentum, an IPV movement wave crashed into shore (the two aforementioned waves of the battered women’s movement, for example); then, after “interest dies down,” the tide receded as “forces of silence” regained prominence, with minimal topographical change made to the shoreline landscape in the wave’s wake. At the time of the trial for the murder of Nicole Brown Simpson, though, the curtains were up as the media helped captivate the world’s attention on domestic violence via coverage of this famous case. Participating in this wave, medical schools turned attention to medical student and resident education on family violence
topics, calling for expansions and improvements. Formalizing these efforts, in 1995, the American Association of Medical Colleges (AAMC) required for the first time in history that medical schools integrate instruction on family violence into their curricula—IPV was now a topic that must be learned in order to practice medicine in the United States. In a fundamental way, IPV was now a physician issue, as Flitcraft had called for a few years prior.

Mathematically, at this stage, clinical medicine aspects of IPV victim patient care added to and embedded within the justice and public health components that already defined the Public Health stage to produce the following updating function equation and result:

Justice + Public Health + Clinical Medicine = IPV.

_The term IPV joins the scene:_ Soon thereafter, in 1999, the Centers for Disease Control and Prevention (CDC) authored a report that called for a change in terminology from “domestic violence” to “Intimate Partner Violence.”

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This important and precise change in language reflected the ongoing cultural influences of the gay rights movement in shaping society’s re-conceptualizations of IPV to recognize violence between people of all sexual orientations and between people in various types of “intimate” relationships. At this time, “intimate partners” were defined to include: current spouses (including common-law spouses), current non-marital partners (heterosexual or same-sex dating partners or boyfriends/girlfriends), former marital partners (divorced spouses, former common-law spouses, separated spouses), and former non-marital partners (heterosexual or same-sex former dating partners or former boyfriends/girlfriends). To further clarify this terminology, the authors of the CDC report divided “violence” into four categories: (1) Physical Violence, (2) Sexual Violence, (3) Threat of Physical or Sexual Violence, and (4) Psychological/Emotional Abuse. This report also called for improved data collection to bolster IPV surveillance and to facilitate analyses that could improve understanding of this issue and how best to respond to it in medical settings.

142 Ibid.
143 Ibid.
144 Ibid.
In response to the CDC’s call for a uniform definition of IPV, Venugopal published “Barriers limiting clinician recognition of intimate partner violence” in *The Dalhousie Medical Journal* and shared the following thoughts that foreshadowed the issues orthopaedic surgeons would soon confront and try to address during the Clinical Medicine stage of the medicalization of IPV in their specialty:\(^{145}\):

> A preventative, facilitative and curative approach to intimate partner violence (IPV), or domestic violence, can be adopted by physicians and medical students, among other health professionals. We may be the first point of contact for many women who suffer abuse or who have endured previous abuse \(^{23}\). It is time we face the moral, medical, cost-effective, and regulatory imperatives to aid women, and to quit "underdiagnosing and misdiagnosing" this common problem \(^{31}\). Curricular, structural, and personal barriers which continue to prevent clinicians from confronting IPV need to be recognized before interventions can be devised. We must further confront the barriers preventing collaboration with community advocates. We must overcome the barriers to devising an

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intervention plan based on sound strategies such as: prevention, safety, empowerment, advocacy, accountability and social justice.

Captured in these lines, in 1999, Venugopal spoke to the tripartite responsibility that clinicians were now expected to uphold as IPV responders in the Clinical Medicine stage of IPV’s evolution; there are justice, public health, and medical components to this role, and how clinicians act in this capacity has moral/ethical, legal, health, and economic implications, among others. Undoubtedly, this was quite an expansive set of skills to expect physicians and surgeons to possess, leading Venugopal to state: “It raises questions about how physicians should be trained to deal with complex conditions intersecting medicine, society, law enforcement and behavioral change where no quick fix adhering to either the classical biomedical model or biopsychosocial model is possible.”¹⁴⁸ Attempting to start answering some of these questions, Venugopal explored and commented on the need for new educational paradigms and novel training approaches in order to bridge, and eventually close, the knowledge gaps (including misconceptions and misinformation) that this type of rapid rate of medicalization of IPV created. Framing this

state of affairs historically, Venugopal introduced his reflective, thoughtful article in this way:

Though recognition now exists of the role which feminist and battered-women's movements played in bringing this issue to national attention during the 1970's, this was not always the case within medicine (7-8). The consciousness-raising of IPV (led by activists) is distinct from the opposition to child abuse, which is felt to have been led mostly by health professionals, and this dichotomy is not without political implications. These implications include the medical profession's slow confrontation of IPV and initial tepid support of community activists. In recent years, however, recognition and subsequent 'medicalization' of IPV is viewed to have partly depoliticized it. Medicine has thus changed IPV from a moral concern and crime into a clinical problem. Like other social concerns, such as alcoholism, drug addiction or elder abuse, medicine has re-framed IPV into an individualized, identifiable and treatable pathology (9). Despite what some protest as medicine's greater IPV jurisdiction, medicalization has brought some distinct advantages. It has given legitimacy to activist

discourse, aided research inquiry, operationalized intervention strategies and added program funding where before it was lacking. This situation should be recognized by clinicians as both a boon and source of frustration for some activists and community leaders (10)\textsuperscript{152}.

Of particular relevance to orthopaedic surgery, the historical dichotomy between child abuse and IPV is an important nuance to highlight: in orthopaedics, as this history will show, surgeons played active roles in the medicalization of child abuse over thirty years prior to participating in the medicalization of IPV in their specialty. Venugopal attributed this to the fact that HCPs served as primary leaders in the early advocacy efforts to create and implement standardized medical care responses to child abuse cases; while, on the other hand, in the case of IPV, mostly non-HCP activists drove the “forces of conversation” during the first wave of the battered women’s movement—during Step 1 in the medicalization of IPV. By making IPV a “clinical problem” during Step 2 of the medicalization of IPV, physicians and surgeons could finally own IPV as something they are knowledgeable about and are competent in managing and

\textsuperscript{152} (10) Krugman RD. From battered children to family violence: what lessons should we learn? Academic Medicine 1995;70:964-967.
could catch up with the advocacy waves that crashed into shore during the Justice and Public Health stages.

*IPV hits the surgical community’s radar:* By the turn of the twenty-first century, Step 2 in the medicalization of IPV gained a stronger foothold in the surgical community, planting seeds for IPV advocacy to sprout in surgical specialties like orthopaedic surgery. In 1999, recognizing IPV as a “major public health problem,” the American College of Surgeons, led by the College’s Committee on Trauma, released its position statement on domestic violence, stating the following about the care for victims of abuse: “It is therefore the responsibility of the treating surgeon not only to care for the immediate injury and to reassure the patient, but also to identify and report potential threats to his or her safety, and to encourage an ongoing safety strategy. Surgeons are encouraged to take a leadership role in their communities, hospitals, and medical schools in preventing and treating domestic violence”153. In this statement, trauma surgeons claimed IPV as a medical issue within their purview; they asserted ownership of the responsibility to (try to) prevent and to treat domestic violence. This process of releasing a specialty-specific position statement on IPV proved to be a common “force of conversation” during Step 2 of the

medicalization of IPV; by signaling to the members of a specialty, such as trauma surgery, that leaders in their field embrace IPV as an opportunity to intervene beneficially in victims’ lives, these position statements influenced the evolution of IPV as a medical issue. However, the question remained: Was the rate of Step 2 in the medicalization of IPV outpacing the speed of the creation and implementation of the requisite clinical training and education experiences and practice tools and resources that clinicians needed to be properly prepared to serve effectively in their new capacities in society? The answer: yes, producing knowledge gaps.

Playing catch up: In 2002, the Institute of Medicine (IOM) recognized the emergence of these knowledge gaps and published Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence as a response to the Health Professions and Education Partnerships Act of 1998 that Congress passed in recognition that “education of health professionals is an important first step in mitigating the problem of family violence”\textsuperscript{154}. In this IOM report, the Committee on the Training Needs of Health Professionals to Respond to Family Violence (an interdisciplinary group of academics, including Campbell) stated the following: “Health professionals are often first to encounter victims of family violence..."\textsuperscript{154}

violence, but little is being done to educate them to deal effectively with this problem. Although curricula exist, training is not consistently offered to those who care for family violence victims. When offered, it is typically of short duration, offered at only one point in the health education program, and frequently limited to only one type of violence”\textsuperscript{155}. To rectify these deficiencies, this IOM report offered four major recommendations: (1) create “family violence centers” under the Department of Health and Human Services to “conduct research on the impact of family violence on the health care system and evaluate and test training and education programs for health professionals”; (2) assess existing family violence curricula for health professionals and develop “approaches to overcoming barriers to training”; (3) “assume greater responsibility for developing, testing, and evaluating innovative training models or programs” in “health care delivery systems and training settings”; and, (4) “create expectations and provide support and incentives for evaluating curricula on family violence for health professionals”\textsuperscript{156}. In this way, this IOM Committee and its publication played powerful roles in Step 2 of the

\textsuperscript{156} Ibid.
medicalization of IPV by making it a national priority to close the knowledge gaps that medicalization had created.

Right away, the Academy on Violence and Abuse (AVA) blossomed as a manifestation of the IOM’s recommendations in action. A diverse group of academic leaders in medicine, nursing, public health, law, and policy domains of healthcare (which included Campbell as well) founded the AVA. From the start, the Mission and the Vision of AVA focused on the health effects of violence and abuse: “The mission of the AVA is to advance health education and research on the recognition, treatment and prevention of the health effects of violence and abuse,” and “[t]he vision of AVA is the prevention of violence and abuse, as well as its identification and care, is fully integrated into the delivery of quality healthcare.”157 As a sister organization to Futures Without Violence, expressing a similar intent to re-conceptualize IPV as a health issue, the AVA “intends to enhance the infrastructure of health care education and highlight the pivotal role health care professionals play in addressing these critical issues, ultimately reframing the limited view of violence and abuse into one that establishes

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them as critical health care issues”\textsuperscript{158}. By emphasizing education and training, the AVA has now worked for over a decade to close IPV knowledge gaps, while simultaneously supporting research that directs understanding of IPV as a health issue. As an agency for medicalization, AVA has played an active role in Step 2 of the medicalization of IPV.

\textit{Stopping before proceeding:} At this point in this story, it seems best to zoom out and to take a moment to summarize several of the key themes of the Clinical Medicine stage of the medicalization of IPV before diving in deeply to explore the nuts and bolts history of how Step 2 in IPV’s evolution played out specifically in the specialty of orthopaedic surgery.

\textbf{(III) CLINICAL MEDICINE STAGE –

Tripartite Medicalization of IPV

Summary:}

- Terminology: “Intimate Partner Violence (IPV)” (introduced by the CDC formally in 1999\textsuperscript{159}; however, the United States National Library of Medicine has not yet established “Intimate Partner Violence” as a MeSH term for PubMed indexing)—"intimate


"partnership" is more flexible and more symmetric than conventional marriage is.

- Primary Responders / Agents of Medicalization: Physicians and surgeons, nurses, and other HCPs in specialties and sub-specialties, such as in orthopaedic surgery.

- Health Condition: IPV conceptualized as a social issue with health implications that benefit from specialty-specific clinical medicine responses—mental, physical, and emotional health effects on patients due to violence and abuse are interpreted and managed within the larger criminal and social justice and public health contexts.

- Signs and Symptoms: Medical specialty specific; for instance, in orthopaedics, they could include broken bones, bruises, chronic pain, etc.—musculoskeletal health issues that fit injury patterns when paired with patient history, review of systems, and physical exam findings.

- Diagnosis (a focus of this stage): Specialty-specific protocols, algorithms, technology-based tools (iPad apps, for instance)—evidence-based standards that provide a framework for approaching each patient’s unique constellation of signs and symptoms.
• Treatment (a focus of this stage): Setting-specific responses (likely involving protocols/algorithms/tools) to specialty-specific presentations combined with collaboration with patient’s primary care and other care teams—individualized responses.

• Prevention: Specialist advocacy and research on IPV; “skilling” of physicians in specialty-specific, targeted manners, such as in orthopaedic surgery fellowship and residency programs or through continuing education courses and requirements for currently practicing orthopaedic surgeons—closing clinicians’ knowledge gaps.

*Thought experiment:* An orthopaedic surgeon sees a patient in clinic with a fractured finger and some bruising on her upper arms. The three historical stages of the medicalization of IPV are in play: (1) Clinical Medicine issue: the surgeon must identify that this fracture is abuse-related because this patient is at risk for psychiatric symptoms, endocrine symptoms (such as chronic cortisol release reducing bone health through osteoporosis), etc., and so the medical response changes when the patient’s health condition is IPV-related; (2) Public Health issue: the surgeon must recognize this “disease/illness”—a deviation from the
desired/normal—and then consider referring the IPV victim to appropriate community resources, such as a family violence shelter; and, (3) Justice issue: the surgeon, if practicing in a mandated reporter state (like California, for instance), has a legal responsibility to report the incident to law enforcement / the legal system; and, if not in one of these states, the surgeon’s counseling abilities have criminal justice implications because perpetrators often escalate the violence after victims disclose. Thus, in order to prepare an orthopaedic surgeon to manage this complex, multi-faceted clinical scenario effectively, proper training is needed in all three aspects. Perhaps, then, using a historical model that builds a tripartite framework for approaching IPV education could prove helpful to achieving that end.

**Step 2: Medicalization of IPV in orthopaedic surgery—It’s seen you, even if you haven’t seen it.**

*A contemporary view:* Orthopaedic surgeons treat victims of violence and abuse. Every day. In hospitals. In clinics. They treat abused children, adults, and elders; they care for patients along the entire family violence spectrum. Consequently, orthopaedic surgeons must be aware of violence and abuse, know how to respond to it, and understand their roles as patient advocates. To do so properly requires perspective. History offers perspective.
The etiology of this perspective: What follows is a deeper exploration of Step 2 in the story of how IPV evolved into an orthopaedic medical issue, as conceptualized currently during the ongoing Clinical Medicine stage of the medicalization of IPV (emphasizing this process in the United States and in Canada). Concerted efforts to understand and to frame orthopaedic surgeons’ roles in caring for victims of violence and abuse drove Step 2 in the medicalization of IPV, adding to and embedding within the aforementioned confluence of socioeconomic, political, and cultural forces that shaped the Justice and the Public Health stages. Like an updating function, the medicalization of IPV produced a modern understanding of this issue in orthopaedic surgery.


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Two years later, in 1976, Akbarnia and Akbarnia\textsuperscript{162} published in *Orthopedic Clinics of North America* the second relevant paper, “The role of orthopedist in child abuse and neglect.” In comparison, a similar search for the criteria “(spouse abuse) AND orthopaedic” returns only 18 articles\textsuperscript{163}. In 2000, decades after the publication of the first orthopaedic article on child abuse, Zillmer\textsuperscript{164} published in the *Journal of the American Academy of Orthopaedic Surgeons* the first article by an orthopaedic surgeon on IPV patient care in orthopaedic surgery, “Domestic violence: the role of the orthopaedic surgeon in identification and treatment”—the Abstract to this paper highlighted (and bridged) the transition from the Public Health stage to the Clinical Medicine stage in orthopaedics:

*Domestic violence is a major public health problem in the United States. As many as 35\% of women visiting hospital emergency departments for trauma care are there because of injuries caused by intimate partner violence. The practicing orthopaedic surgeon may come in contact with these women in the emergency department as well as in the office setting. The ability to identify victims of abuse*


requires a sensitive approach and a specific set of skills. Once the victim has been identified, appropriate referral to local agencies is critical to help ensure the victim's safety. The issues surrounding identification, documentation, inquiry about safety, and activation of community services need to be incorporated into the core curriculum of resident training programs and the continuing education of the practicing orthopaedic surgeon.

Showing how aspects of the stages of the medicalization of IPV have overlapped and have interacted via an iterative updating function, Zillmer’s article blended the “screen-and-refer” approach that the Public Health stage established with a call for targeted, specialty-specific training in orthopaedic residency programs and in continuing education for practicing surgeons, a hallmark of the Clinical Medicine stage. Then, in 2002, Zillmer\textsuperscript{165} published in Orthopaedic Nursing the second paper on this topic, “A call for action,” establishing an important connection with orthopaedic surgeons’ nursing colleagues. Moreover, Zillmer recalls the dichotomy between violence and abuse awareness in children and in adult patients dating back to her residency training in the late 1980s: "I did my training in the Bronx in New York, and I felt that our awareness of intimate partner violence at that time wasn’t as

good as it should be. It wasn’t as good as it was for child abuse”\textsuperscript{166}. Following Zillmer’s pioneering leadership at the turn of the twenty-first century, as becomes clear later in this history, the literature on IPV awareness, response, and advocacy in orthopaedic surgery blossomed. Furthermore, a search for the criteria “(elder abuse) AND orthopaedic” returns only 5 articles\textsuperscript{167}, starting with “Elder abuse: the role of the orthopaedic surgeon in diagnosis and management” by Chen and Koval\textsuperscript{168} in 2002 in the \textit{Journal of the American Academy of Orthopaedic Surgeons}.

Moreover, several other early articles are worth noting for historical context. In 1992, Henry et al.\textsuperscript{169} published in the \textit{Journal of the Kentucky Medical Association} the first article about domestic violence by a physician from an orthopaedic department, “Domestic violence—the medical community’s legal duty,” though this article did not focus on IPV response in the orthopaedic setting. In 1993, the first article relevant to IPV in clinical orthopaedics appeared in the nursing literature:

\textsuperscript{166} Zillmer DA. Personal interview. 27 June 2012.
two nurses, Varvaro and Lasko\textsuperscript{170}, published “Physical abuse as cause of injury in women: information for orthopaedic nurses” in Orthopaedic Nursing. Then, in 1998, Varvaro\textsuperscript{171} followed up by publishing “Violence against women: the role of orthopaedic nurses in the identification, assessment, treatment, and care for the abused woman” in Orthopaedic Nursing, which outlined how nurses could participate in IPV screening and response:

Violence against women is a significant public health problem that affects women of all age groups across the life span. This article presents a review of domestic violence against women and outlines the role of orthopaedic nurses in the identification, assessment, treatment, and care of women patients with injuries or medical problems sustained as a result of domestic abuse from an intimate other. Key interventions for the treatment and care of abused women include (a) acknowledging the abuse, (b) discussing safety planning, (c) discussing the pattern of abuse, (d) anticipating and respecting the partial denial, (e) reassuring the woman that abuse is not her fault; (f) informing the woman that no one deserves to be abused, (g) telling the woman gently that help is available, (h) reminding the woman that domestic violence is a crime, (i) referring to


community resources, and (j) allowing the woman to decide which support services and options are safe for her situation.

Like Zillmer’s articles and the American College of Surgeon’s position statement, this article recognized IPV as a public health problem; and then, from this basis, the next stage in the evolution of IPV awareness, response, and advocacy became investigating, framing, and clarifying how HCPs in the specialty of orthopaedic surgery, in an interdisciplinary fashion, should approach and manage patient care for IPV victims in orthopaedic settings.

As a PubMed survey, this brief review reveals two findings: (1) IPV is a relatively new area of academic and clinical focus in orthopaedic surgery, especially in comparison to child abuse; and, (2) the evolution of orthopaedic care for IPV victims has progressed inter-professionally, with both nurses and surgeons working to advance awareness, response, and advocacy in the field. Notably, nurses led the charge years before orthopaedic surgeons championed this cause. This relative historical silence on IPV by orthopaedic surgeons signaled an opportunity for them to lead patient care improvements.

Leading transformational change in orthopaedic surgery: At the turn of the twenty-first century, IPV awareness shifted to the specialty-specific setting of orthopaedic surgery: Step 2 in
the medicalization of IPV. IPV response and advocacy in orthopaedic surgery started gathering momentum a little over a decade ago. In 1999, the Ruth Jackson Orthopaedic Society (RJOS)\textsuperscript{172}—an organization for female orthopaedic surgeons—selected IPV (as a topic under the umbrella of “family violence”) as one of its main advocacy issues to address\textsuperscript{173}. Zillmer, a past President of RJOS, headed this project, and she presented on family violence via an exhibit booth at the American Academy of Orthopaedic Surgeons’ (AAOS) annual meeting in 2000\textsuperscript{174}. Illustrating a theme, as occurred during the preceding decades of IPV history, advocacy for gender and ethnic issues coincided: increased awareness of minority groups in orthopaedic surgery bubbled up with the founding of the J. Robert Gladden Society (JRGS) in 1998\textsuperscript{175,176}:

\textit{A group of concerned members of the American Academy of Orthopaedic Surgeons (AAOS) have worked with the leadership in the AAOS to advance the ideals of ethnic and gender diversity}

\textsuperscript{173} Zillmer DA. Personal interview. 27 June 2012.
in our profession. The J. Robert Gladden Society (JRGOS) has evolved from this and other roots in the African-American orthopaedic community. Our society emphasizes education and the development of the practice of culturally competent medicine. Our goal is to eliminate ethnic disparities in health care. Simply stated, the JRGOS stresses the need for minority orthopaedic surgeons to work collaboratively to address important patient and educational concerns. [...] At this time, we are in dialogue with the Ruth Jackson Orthopaedic Society and the AAOS Diversity Committee in an effort to increase our effectiveness. In the future the JRGOS will continue to support activities as they relate to education of surgeons and patients, health care policy and medical research.

As this JRGS history statement communicates, the AAOS expressed support for and openness to conversations about ethnic and gender issues that orthopaedic surgeons were silent about for many years. Building on this momentum, Zillmer forged ahead and continued fostering these conversations by publishing in the Journal of the American Academy of Orthopaedic Surgeons the first article by an orthopaedic surgeon on IPV care in orthopaedic settings, “Domestic violence: the role of the orthopaedic surgeon in
identification and treatment”\textsuperscript{177}. As mentioned previously, this article examined the orthopedic surgeon’s role in caring for IPV victims, providing the first formal call to action within the specialty. It also identified the need to improve orthopaedic residency training and continuing education on this topic. Next, in 2002, Zillmer\textsuperscript{178} published “A call for action” in \textit{Orthopaedic Nursing}. This article presented the results from an open-forum symposium on family violence held at the AAOS’s annual meeting that year for the National Association of Orthopaedic Nurses\textsuperscript{179}. This symposium highlighted the tremendous resources that nurses (as well as physician assistants, clinical technologists, and medical assistants) can serve as in screening for and responding to IPV victims\textsuperscript{180}.

Additionally, in 2002, Zillmer headed the Task Force on Family Violence formed by the AAOS to develop and adopt a position statement on family violence\textsuperscript{181,182}. At that time, some orthopaedic surgeons felt that IPV was “not an orthopaedic issue”—a few even expressed overt hostility

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\textsuperscript{179} Zillmer DA. Personal interview. 27 June 2012.
\textsuperscript{180} Ibid.
\textsuperscript{181} Ibid.
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about it—so the term “family violence” was used to include IPV, along with child abuse and elder abuse, both less controversial topics\textsuperscript{183}. These expressions of hostility (“forces of silence”) by orthopaedic surgeons conveyed resistance to Step 2 of the medicalization of IPV. One could speculate that these orthopaedic surgeons contested further medicalization of IPV in their specialty because they were not yet trained properly to respond to IPV victim patients appropriately, and thus they likely felt uncomfortable embracing their new roles as IPV responders and advocates. Recognizing a need to change professional norms around IPV in orthopaedic surgery, the Task Force on Family Violence proceeded as an agent for medicalization. After its acceptance, the original AAOS Advisory Statement affirmed that “family violence, in the form of child abuse, adult domestic violence and elder abuse, is a major public health problem in the United States. The Academy is committed to providing appropriate care to victims of family violence whether they present to an emergency department [or] orthopaedic office/clinic”\textsuperscript{184}. Today, the AAOS provides this Information Statement

\textsuperscript{183} Zillmer DA. Personal interview. 27 June 2012.
online. In this Statement, “Child Abuse or Maltreatment, Elder Maltreatment, and Intimate Partner Violence (IPV): The Orthopaedic Surgeon’s Responsibilities in Domestic and Family Violence,” the Academy lists facts, resources, and guidelines for orthopaedic surgeons to consider utilizing in practice, all of which have evolved since 2002 when Zillmer and colleagues first initiated this effort to shape the trajectory of the medicalization of IPV most optimally.

Soon thereafter, more orthopaedic IPV tools were produced. In 2003, Zillmer et al. released an instructional resource, “Family violence: tools for the orthopaedic surgeon,” after presenting this material as a Continuing Medical Education (CME) course for orthopaedic surgeons at the AAOS’s annual meeting in 2002. This resource and several others pertinent to IPV are currently available online via the AAOS’s Orthopaedic Knowledge Online Journal (orthoportal.aaos.org) by searching for “family violence.” Two of these resources are: (1) “It’s OK to Talk to Your

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186 Ibid.
Orthopaedic Surgeon About Family Violence,”¹⁸⁹ which is a message urging orthopaedic surgeons to respond to the AAOS teaming up with the AMA in its National Campaign Against Family Violence; and, (2) “Family Violence: Facts and Tools for the Orthopaedic Surgeon,”¹⁹⁰ which is a lecture series by Zillmer and Kocher, in conjunction with RJOS, on orthopaedic aspects of child abuse, adult domestic violence, and elder abuse. Also in 2003, Zillmer and her colleagues at RJOS sent a Women’s Health CD—that included information about care for violence and abuse victims—to the deans of all the medical schools in the United States to provide educational materials that could help improve IPV curricula and training for medical students¹⁹¹. Overall, these types of specialty-specific tools were natural manifestations of the maturing Clinical Medicine stage of the medicalization of IPV; they moved clinical responses beyond the generalized screen-and-refer protocols that the Public Health stage established. In this way, the Clinical Medicine stage emphasized increasingly individualized, nuanced approaches to caring for IPV victims as patients.

¹⁹¹ Zillmer DA. Personal interview. 27 June 2012.
Clearly, the start of the twenty-first century was filled with a flurry of activity around IPV as orthopaedic surgeons like Zillmer and organizations like the AAOS and RJOS recognized openly that “[a]s medical specialists trained in the diagnosis and treatment of musculoskeletal disorders, orthopaedic surgeons can be the first medical providers to treat victims of family violence. That puts orthopaedic surgeons in an exceptional position to link victims with community family violence resources and to facilitate intervention [...]”\(^{192}\). Expounding on this position, Zillmer shared that orthopaedic surgeons “must look for the red flags of abuse, including inconsistencies between the injury and a patient's description of what caused it”\(^{193}\). In the same vein, another orthopaedic surgeon concluded, “The bottom line is, orthopaedic surgeons need to become more aware of the possibility of family violence as the etiology of not only obvious injuries, but also chronic conditions. We need to ask the question, 'Has someone hurt you?'”\(^{194}\). Taken together, these statements indicate that, in the early 2000s, orthopaedic surgeons were aware of IPV as an issue that they could respond to effectively as empathetic patient advocates for


\(^{193}\) Ibid.

\(^{194}\) Ibid.
victims of violence and abuse. As a theme of medicalization, this call for HCPs to look beyond the symptoms of IPV to inquire about etiology played out in orthopaedic surgery, as it had previously in other clinical settings like emergency medicine and OB/GYN.

Passing the baton: In the years that followed this early advocacy, the orthopaedic surgery literature on IPV blossomed when Bhandari started an academic program to investigate IPV as a health issue in the orthopaedic trauma setting. Bhandari took the baton from Zillmer and ran with it. In 2006, Bhandari et al.\textsuperscript{195} published “Musculoskeletal manifestations of physical abuse after intimate partner violence” in the \textit{Journal of Trauma}, reporting the results of the initial study conducted by the Violence Against Women Health Research Collaborative. Notably, this paper marked the first use of the term “intimate partner violence” by an orthopaedic surgeon in the orthopaedic literature. This study found that musculoskeletal injuries (sprains, fractures/dislocations, and foot injuries) accounted for 28% of the IPV symptoms, making it the second most common IPV patient presentation\textsuperscript{196}. This work prompted Bhandari to approach the Canadian Orthopaedic Association (COA)


\textsuperscript{196} Ibid.
about creating a national position statement on orthopaedic surgeons’ roles in caring for IPV victim patients. Bhandari viewed this as a chance to recognize IPV as a real orthopaedic issue rather than as “a problem of other groups”. He believed that by embracing IPV cases as opportunities to provide compassionate patient care—to advocate for victims of violence and abuse—orthopaedic surgeons could positively impact people’s lives. However, when Bhandari approached the COA about establishing a position statement, he encountered—just as Zillmer did several years prior—strong pushback from some orthopaedic surgeons who did not view IPV as an orthopaedic issue. In fact, Bhandari recalls one person saying that addressing IPV formerly would “open a can of worms that we may not want to get into right now.” So, in Canada, as in the United States, the national orthopaedic association grappled with IPV, unsure about whether this was more of a “social services issue than a surgical issue”. To turn the tide, Bhandari and colleagues did what all scientists do: they gathered, analyzed, and presented data.

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197 Bhandari M. Personal interview. 27 June 2012.
198 Ibid.
199 Ibid.
200 Ibid.
201 Ibid.
202 Ibid.
The tide rolls in: Leading collaborative efforts to research IPV in the orthopaedic setting, Bhandari and colleagues continued to study, publish, and present. As Bhandari recounts, “I look at change as being a series of small incremental steps that amount to a major leap forward over a period of a decade. In 2003, we started a research program to understand IPV in the orthopaedic trauma setting.” Instead of relying on opinions about this issue, Bhandari embraced the scientific process: “You can force people into your opinion if you are forceful enough, but opinion, these days, does little in an era of evidence-based orthopaedics. So, I sought to identify evidence for the prevalence of IPV in the orthopaedic surgery setting, and there was minimal evidence to find.” To remedy this paucity of evidence situation, Bhandari collaborated with colleagues to publish five more papers.

In 2008, Bhandari et al. published “(Mis)perceptions about intimate partner violence in women presenting for orthopaedic care: a survey of Canadian orthopaedic surgeons” in The Journal of Bone and Joint Surgery to gauge orthopaedic surgeons’ perceptions, attitudes, and

203 Ibid.
204 Ibid.
understanding of IPV. The results from this survey of 186 orthopaedic surgeons indicated that many of them felt uncomfortable with and unprepared for IPV patient care, despite 91% of them expressing the belief that IPV was relevant to their practices\textsuperscript{206}. Additionally, as a first pass at better understanding the prevalence of IPV in orthopaedic settings, this surveyed found that 95% of respondents estimated that <10% of their patients were IPV victims; and, more specifically, 80% estimated that <1% of their patients were IPV victims\textsuperscript{207}. These prevalence perceptions proved to be inaccurate, exposing knowledge gaps, as Bhandari’s next investigation uncovered.

These survey results motivated Bhandari and colleagues to create a multi-center, cross-sectional study—“PRevalence of Abuse and Intimate Partner Violence Surgical Evaluation (P.R.A.I.S.E.)”—to assess whether orthopaedic surgeons’ perceptions of the prevalence of IPV cases in their clinics were accurate or were misconceptions\textsuperscript{208}. In 2011, Bhandari et al.\textsuperscript{209} published “The prevalence of intimate

\textsuperscript{206} Ibid.
\textsuperscript{207} Ibid.
partner violence across orthopaedic fracture clinics in Ontario” in The Journal of Bone and Joint Surgery to report their findings. This study of 282 injured women who were seen for care at two Level-1 trauma centers found that 32% of these patients experienced IPV within the past year. This revealing data point demonstrated a knowledge gap in beliefs: orthopaedic surgeons’ perceptions of the prevalence of IPV cases in their practices were grossly inaccurate. This revelation helped Bhandari communicate with other orthopaedic surgeons about the relevance of IPV in their specialty. As Bhandari reflects, “The main thing that we have to do is convince surgeons that this is not somebody else’s issue; this is an issue that we are dealing with every single day in our clinics. We have to convince surgeons, quite frankly, that their perceptions about IPV are in fact gross misrepresentations, if not misperceptions, based on the truth.” Like Flitcraft who in 1993 called for physicians to take ownership of IPV as a clinical medicine issue, Bhandari called for surgeons to take ownership of IPV as a clinical orthopaedic issue. Importantly, this study demonstrated that the rate of Step 2 in the medicalization of IPV in orthopaedic surgery had outpaced the speed of the creation and implementation of requisite training experiences, tools, and

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210 Ibid.
211 Bhandari M. Personal interview. 27 June 2012.
resources in parallel. However, this study did not reveal when and where in the orthopaedic surgery training hierarchy that these knowledge gaps began to widen.

After studying orthopaedic surgeons in practice, Bhandari and colleagues moved on to survey surgical residents and medical students, drilling down to the training level to evaluate when and where these misconceptions about IPV begin. In 2011, Sprague et al.\textsuperscript{212} published “Perceptions of intimate partner violence: a cross sectional survey of surgical residents and medical students” in the \textit{Journal of Injury and Violence Research} to report the results from this training assessment study. It showed that Canadian medical students and surgical residents believed IPV was relevant to clinical practice but felt unprepared to manage it due to inadequate education\textsuperscript{213}. The majority of medical students (91.2\%) and surgical residents (96.9\%), just like the orthopaedic surgeons surveyed in the P.R.A.I.S.E. study, estimated that 10\% or less of the patients in their intended practices were IPV victims (when, in reality, the percentage is much higher, likely closer to the 32\% that Bhandari et al. published in 2011)\textsuperscript{214}. In analyzing this study, these results indicated that misperceptions by attending surgeons get passed down to

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\item \textsuperscript{213} Ibid.
\item \textsuperscript{214} Ibid.
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medical student and to resident trainees and/or that misperceptions about IPV are prominent at all levels of training. Like previous studies and articles, these results reiterated the need for “skilling” current and future orthopaedic surgeons about IPV epidemiology, its clinical manifestations in orthopaedic settings, and ways to utilize IPV practice tools to provide appropriate patient care.

Perceiving the need for better tools for orthopaedic surgeons, surgical residents, and medical students, Sprague, Bhandari and colleagues compared several IPV screening instruments that clinicians could use in day-to-day practice. In 2012, Sprague et al.\textsuperscript{215} published “Screening for intimate partner violence in orthopedic patients: a comparison of three screening tools” in the \textit{Journal of Interpersonal Violence} to report the results of this evaluation. Using data from the P.R.A.I.S.E. study, they compared three commonly used and accepted screening approaches: (1) direct questioning; (2) the Women Abuse Screening Tool (WAST); and, (3) the Partner Violence Screen. This analysis showed that the prevalence of IPV varied depending on which screening instrument was utilized: 30.5\% of patients screened positive using direct questioning, 12.4\% screened positive using the Women Abuse Screening Tool, and 9.2\% screened positive using the

Partner Violence Screen\textsuperscript{216}. From this result, the authors suggested that orthopaedic clinics could implement direct questioning for IPV screening to improve disclosure by patients\textsuperscript{217}. Further research was needed, though, because direct questioning, as a method for “diagnosing” IPV, must be paired with a modality for “treating” IPV (in order to prove effective in practice), so orthopaedic surgeons continued to inquire and to reflect about these dynamics.

\textit{The COA joins the conversation}: In parallel, as a driving “force of conversation,” Bhandari continued advocating for IPV with the COA. In early 2009, he led the Intimate Partner Violence Working Group, again advising the COA to formalize a position statement that delineated clearly the roles and responsibilities of Canadian orthopaedic surgeons in care for IPV victims\textsuperscript{218}. This Group concluded: “Most importantly, it is the responsibility of every orthopaedic surgeon to empower themselves with knowledge and understanding of existing literature and guides to identification and appropriate management of victims of intimate partner violence. Let orthopaedic surgeons lead the way to advancing the safety and care of abused women in

\textsuperscript{216} Ibid.
\textsuperscript{217} Ibid.
their practices”\textsuperscript{219}. Later that year, the COA adopted an official position statement on IPV\textsuperscript{220}. Today, this Position Statement is available online on the COA’s Web site, and it provides background information on the issue, outlines the roles and responsibilities of orthopaedic surgeons, and lists appropriate steps to take to screen for and respond to victims of IPV effectively\textsuperscript{221}. Additionally, this Position Statement uses the term “intimate partner violence” directly: “The Canadian Orthopaedic Association recognizes that intimate partner violence is a significant social determinant of morbidity and mortality, and that orthopaedic surgeons are well positioned to identify patients living with IPV and initiate an intervention. Therefore, the COA encourages its members to educate themselves further about intimate partner violence and considers it good medical practice to take steps to identify and offer assistance to its victims”\textsuperscript{222}. In a straightforward manner, this Statement signals to orthopaedic surgeons in Canada that “my national association believes intimate partner violence is important”\textsuperscript{223}. Currently, the COA is working on educational materials and clinical toolkits for orthopaedic surgeons to turn to for assistance in

\textsuperscript{219} Ibid.
\textsuperscript{220} Ibid.
\textsuperscript{222} Ibid.
\textsuperscript{223} Bhandari M. Personal interview. 27 June 2012.
dealing with this challenging, complex issue\textsuperscript{224}. Like the AAOS, the COA has served as an agent for medicalization during Step 2 in IPV’s Clinical Medicine stage evolution by assisting orthopaedic surgeons as they carve out their niche in society’s multi-faceted support system for victims of violence and abuse.

\textit{Fostering a global conversation:} Building on successful IPV advocacy in the United States and in Canada, it appears that a global conversation about IPV in orthopaedic surgery is underway. At the end of 2012, Sohani et al. published “Feasibility of screening for intimate partner violence at orthopedic trauma hospitals in India” in the \textit{Journal of Interpersonal Violence} to share the findings of a study that administered two questionnaires—the Composite Abuse Scale (CAS) and the Woman Abuse Screening Tool (WAST)—to 47 female patients in trauma clinics in India to assess the feasibility of screening for IPV regularly in this setting\textsuperscript{225}. WAST asks patients questions about ever experiencing physical, sexual, and emotional abuse, while CAS asks patients questions about how often (ranging from never to daily) their partner has behaved violently/abusively in the past 12 months. This study (1) found an IPV

\textsuperscript{224} Ibid.
prevalence of 30% using WAST and of 40% in the past 12 months using CAS; (2) observed that more patients screened positive when the questionnaire was conducted as a self-report form as compared to when administered by an in-person interview; (3) and, overall, determined that screening for IPV is feasible in this setting\textsuperscript{226}. In addition, this study included interviews with the four HCPs who administered the IPV screening instruments to capture their perceptions of how patients viewed their experiences participating in IPV screening. The comments from these interviews reveal that Indian society continues to contest medicalization of IPV. Here are a few of these comments\textsuperscript{227}:

1. “In India, the population isn’t very open to answering the questions. Even the educated and affluent individuals wouldn’t be comfortable answering the questions.”

2. “If they are rich patients, they may be offended and choose not to return.”

3. “We should not get involved in a patient’s intimate life … that is not our profession. Ultimately, the patient

\textsuperscript{226} Ibid.
\textsuperscript{227} Ibid. 12-13.
may undergo abuse again if they are caught answering questions. It is an unusual situation for doctors.”

Even though this study was conducted in an orthopaedic trauma setting—a characterization of the Clinical Medicine stage of the medicalization of IPV—these quotes indicate that the medicalization of IPV in India may still be mostly in the Justice stage, with IPV patient advocates acting as agents for medicalization by working to bridge the transition to the Public Health stage where general HCPs recognize IPV as a health issue and then intervene accordingly by screening for violence and abuse and referring IPV victim patients to appropriate resources. If this is the case, then extrapolating approaches to IPV from Canada and/or the United States to India may prove challenging at first if Indian culture has not already re-conceptualized IPV as a health issue. If so, it will be informative to follow in the coming years how IPV evolves as a social issue in India. Perhaps this progression will continue to be influenced by the global conversations that IPV patient advocates like Bhandari and Zillmer have fostered in the United States and in Canada since the turn of the twenty-first century. Ultimately, this study illustrates once again that, at its core, IPV is a culturally constructed social justice issue; it takes the confluence of socioeconomic, political, cultural, and professional forces coupled with
individual leadership/advocacy efforts combining at the right historical intersections in time and in space to drive the re-conceptualization of IPV as a health issue and the subsequent medicalization of IPV.

*IPV awareness, response, and advocacy in orthopaedics evolve:* Meanwhile, in the United States and in Canada, IPV continues to evolve as an orthopaedic medical issue, as demonstrated by four publications on IPV appearing in the orthopaedic literature already in 2013. Firstly, Della Rocca et al. recognized that not enough data exists assessing orthopaedic surgeons’ knowledge about IPV. To remedy this opacity, this group surveyed 153 surgeon members of the Orthopaedic Trauma Association (OTA) and then published “Orthopaedic surgeons’ knowledge and misconceptions in the identification of intimate partner violence against women” in *Clinical Orthopaedic and Related Research* to share the results. This study revealed several misconceptions that further demonstrate the knowledge gaps that persist in orthopaedic surgery as a result of the rate of the medicalization of IPV outpacing the speed of the creation and implementation of the requisite IPV training experiences and educational resources in parallel. Two of the key

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misconceptions cited were beliefs that “victims must be getting something out of the abusive relationship (16%)” and that “some women have personalities that cause the abuse (20%)”\textsuperscript{229}. These misconceptions represent blaming-the-victim responses to IPV, which could either represent efforts to contest the further medicalization of IPV or could reflect misinformed assumptions about IPV that orthopaedic surgeons acquired culturally and that continue to persist in society. Either way, this study also found that about 30% of the surgeons surveyed “expressed concerns regarding lack of knowledge in the management of abused women,” so the net takeaway is the same: “This shows a strong need for implementation of standard practice guidelines and continuing education concerning IPV screening and management in orthopaedics”; thus, “[t]argeted educational programs on IPV are needed for surgeons routinely caring for injured women”\textsuperscript{230}. It is also important to highlight the result that only 8% of the OTA surgeons surveyed agreed with the statement that it was “Not my place to interfere with couples’ conflict resolution” (leaving 22% neutral and 71% in disagreement with that statement) because this indicates strongly that the vast majority of orthopaedic surgeons surveyed believe that they have a therapeutic role to play in

\textsuperscript{229} Ibid.
\textsuperscript{230} Ibid.
responding to IPV victim cases\textsuperscript{231}. And, 72\% agreed with the statement “Providing more IPV information to ortho surgeons could be beneficial to stopping abuse in some cases” (while 19\% were unsure, leaving 9\% in disagreement), so the evidence from this survey indicates that orthopaedic surgeons are settling into and trying to embrace their new roles as specialty-specific IPV responders\textsuperscript{232}. Accepting this role in this manner shows that orthopaedic surgeons in North America are, overall, participating actively in the Clinical Medicine stage of the medicalization of IPV, and they are expressing interest in shaping the evolution of IPV awareness, response, and advocacy in their specialty. For example, 49\% of survey respondents answered “Yes” to the statement “I would like to receive training on the assessment and treatment of IPV” (while 21\% were unsure and only 27\% answered “No”)\textsuperscript{233}. With this openness to learning and to improving clinical practice in place, in the near future, implementation of training experiences and resources—such as educational courses on IPV during orthopaedic surgery residency training—and expansion of practice guidelines and tools—such as an app for IPV screening in orthopaedics specifically—may succeed in new, transformative ways as orthopaedic surgeons continue to claim IPV as an

\textsuperscript{231} Ibid.
\textsuperscript{232} Ibid.
\textsuperscript{233} Ibid.
orthopaedic medical issue—just as Flitcraft\textsuperscript{234} called for twenty years ago—and to carve out their roles as IPV victim advocates.

Secondly, illustrating this transformation in action, Sprague, Bhandari, and colleagues reviewed the existing surgical research literature on IPV and then channeled this information into guidelines for developing and evaluating IPV identification and support programs in orthopaedic settings. Carrying historical significance, these guidelines represent exactly what the IOM envisioned with the recommendations put forward in its 2002 report, \textit{Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence}\textsuperscript{235}. Sprague et al.\textsuperscript{236} published these findings as “Intimate partner violence and Musculoskeletal injury: bridging the knowledge gap in Orthopaedic fracture clinics” in \textit{BMC Musculoskeletal Disorders}, outlining six steps for implementing an evidence-based, structured approach to IPV: “Item 1) Decide who to include in IPV identification programs; Item 2) Determine who should ask about IPV; Item 3) Determine the method of identification; Item 4)

Ensure confidentiality and patient safety in the clinic setting; Item 5) Develop social support programs; Item 6) Evaluate the program”\textsuperscript{237}. In an era of evidence-based orthopaedic surgery, bridging IPV knowledge gaps requires crafting pilot programs, testing them out in practice, assessing their effectiveness, implementing changes to improve how they work, and then sharing findings with the global orthopaedic community—in this way, it is an iterative, constantly-updating scientific approach to the management of a clinical medicine issue.

Lastly, this evidence-based, scientific approach helped shine more light on the unknowns about IPV as an orthopaedic medical issue when Bhandari, Sprague and colleagues published two more informative studies in 2013: (1) “Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: a multinational prevalence study”\textsuperscript{238} in \textit{Lancet}, concluding that “Orthopaedic surgeons should be confident in the assumption that one in six women have a history of physical abuse, and that one in 50 injured women will present to the clinic as a direct result of IPV. Our findings warrant serious

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\item \textsuperscript{237} Ibid. 8.
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consideration for fracture clinics to improve identification of, respond to, and provide referral services for, victims of IPV”;
and, (2) “Patient opinions of screening for intimate partner violence in a fracture clinic setting: P.O.S.I.T.I.V.E.: a multicenter study” in *The Journal of Bone and Joint Surgery*, determining that “the majority of patients endorse active screening for intimate partner violence in orthopaedic fracture clinics”\(^{239}\). If there were still questions as to whether IPV is a common orthopaedic medical issue and/or as to whether patients would appreciate their orthopaedic surgeons’ assistance in dealing with their challenging circumstances, these studies provide guidance that could help orthopaedic surgeons optimize the trajectory of the medicalization of IPV. With these pieces in place, this history suggests that this specialty-specific, focused approach to the management of IPV is indicative of a mature state in the Clinical Medicine stage of the medicalization of IPV. With this momentum in place, perhaps another wave is cresting, preparing to start crashing.

**Net results:** This history of the evolution of IPV awareness, response, and advocacy in orthopaedic surgery—analyzed through the lens of medicalization—presents a

framework that could be harnessed for the creation and implementation of targeted training and educational programs. Several themes emerged that current and future orthopaedic surgeons could draw on to continue advancing orthopaedic care for IPV victims (Fig. 1). Going forward, orthopaedic surgeons could build on the conversations that individual surgeons and surgical associations have started to help close the knowledge gaps that resulted—as would be expected to happen naturally—from the rapid medicalization of IPV in North America that started in the 1970s (Fig. 2). Hopefully, by recognizing the legal, public health, and clinical medicine roles that orthopaedic surgeons play in caring for IPV victims as patients, the tripartite framework employed in this discussion could turn the story of how IPV evolved into an orthopaedic medical issue into an educational model for training current and future orthopaedic surgeons. In turn, more orthopaedic surgeons may better understand why they are now encouraged to serve as IPV advocates and what resources and tools are available to make that transition both successful and fulfilling.

**Concluding Reflections**

Recounting the following final reflection by Bhandari summarizes the medicalization of IPV in orthopaedic surgery well. At the outset, orthopaedic surgeons contested
medicalization, sometimes vehemently: “When we started this in 2003, there was almost a uniform concern and almost a dismissal that this wasn’t the orthopaedic surgeon’s domain. We should be careful not to push this too far” 240. This resistance manifested in ways that maintained silence on IPV in orthopaedics, as Bhandari recalls (these “forces of silence”): “You know, I had a hard time getting our first paper published. Many journals came back saying, ‘This is nice work, but this is not an orthopaedic surgeon’s issue.’ I had to really shop around that paper—and I thought, ‘My goodness’—I knew it was going to really be an uphill battle on every single move and that it would be very difficult to keep the momentum going” 241. However, Bhandari and his colleagues persevered because they believed that IPV awareness, response, and advocacy were part of the orthopaedic surgeon’s scope of practice, that orthopaedic surgeons could be trained to respond appropriately to IPV victims to improve their health states in positive ways: “With that being said, we persevered: we grew our network, and, in June of 2012, we received an award of merit from the Canadian Orthopaedic Association for the work we are doing with IPV” 242. In powerful, far-reaching ways, this historical shift in perspective signals a profound change: “So, clearly it’s

240 Bhandari M. Personal interview. 27 June 2012.
241 Ibid.
242 Ibid.
gone from “This is not our problem’ to ‘We should be making it our issue; we should be rallying behind it””243. In the case of IPV, the medicalization of this human condition in orthopaedic surgery has changed how orthopaedic surgeons think about their roles in both the healthcare system and in society, expanding orthopaedic surgeons’ expected and entrusted healing capacities and clinical responsibilities to include IPV awareness, response, and advocacy.

Yet, in light of the resultant knowledge gap that still exists as a result of medicalization outpacing requisite education and training adaptations in parallel, Bhandari and the Canadian Orthopaedic Association are working to close this gap with both stopgaps and with long-term programming plans, such as continued research to improve protocols, tools, and training: “It’s to the point that the Canadian Orthopaedic Association is recognizing IPV as a forefront topic for us. The Canadian Orthopaedic Association wants to continue our group’s work, and they want to help facilitate it so that every Canadian orthopaedic surgeon is informed and aware. So, to me, that’s a pretty exciting shift since 2003”244. An exciting shift indeed: from a private and then a social affair known as “wife battering” to a mainstream public health issue known as “domestic violence” to a clinical medicine specialty-

243 Ibid.
244 Ibid.
specific issue known as “Intimate Partner Violence” that orthopaedic surgeons serve as patient advocates for, the medicalization of IPV in orthopaedic surgery illustrates well how medicine evolves over time as the confluence of socioeconomic, political, cultural, and professional forces interact to shape how we think about health and disease and what roles we expect our healers, such as orthopaedic surgeons, to play.

*Where to go from here?* With this discussion of history in place, it is now time to step back, reflect, and consider the implications of this medicalization of IPV story for training and for practice. Chapter 3 ventures into and attempts to explore some of the nuances of those domains.
CHAPTER 3

Medicalization of IPV in orthopaedics: the implications

Critical analysis: To shape the trajectory of the medicalization of IPV most optimally, this transformation of IPV from a private affair to a social issue to a justice issue to a public health issue to a clinical medicine issue requires critical analysis. Two cautious IPV analysts, Bell and Mosher—the authors of “(Re)fashioning Medicine’s Response to Wife Abuse”—point out that the research of the 1970s and 1980s highlighted HCPs’ inadequate responses to victims of violence and abuse, prompting clinicians to respond to this perceived deficiency by lobbying “successfully for the identification, diagnosis, treatment, and management of abused women”²⁴⁵. In turn, this response set up a tension that has pervaded medical care for IPV victims ever since: individualization versus standardization. This tension arose as HCPs worked to change the extant healthcare culture relative to IPV awareness, response, and advocacy. As a strategy, standardization can be a powerful tool for changing medical culture: by creating and implementing protocols, algorithms, checklists, standards of care, et al., healthcare leaders encourage HCPs to change their behaviors to conform to the

expectations and responsibilities that these clinical practice support modalities require. For example, one such requirement of an orthopaedic surgeon could be to always ask a patient directly if she has been abused if she presents with a metacarpal fracture during pregnancy. This conditional requirement creates a standard; this standard then shapes clinicians’ behaviors at the point of care. Ideally, this standard would serve as a tool that orthopaedic surgeons could use in practice to manage care for victims of violence and abuse. Potentially, though, this type of standardization could compromise respect for individuality and for patient autonomy. Striking the right balance along the standardization-individualization patient care spectrum seems to be key to optimizing the medicalization of IPV in orthopaedic surgery.

In considering this tension, it is informative to appreciate how IPV standards change orthopaedic surgeons’ roles. To start, orthopaedic surgeons’ perceptions of IPV are strongly influenced by wider social and cultural forces and norms. To this end, Bell and Mosher share the following: “The attitudes of physicians are, of course, subject to the characterizations of woman abuse arising from broader societal attitudes and beliefs concerning the sanctity and privacy of family, women’s role and position in society, male
privilege, and public tolerance of abuse”\textsuperscript{246}. Given this multifactorial basis for orthopaedic surgeons’ perceptions of IPV, efforts to standardize medical care for IPV victims could be perceived by some as conflicting with individuality—for both providers and for patients—because standardization (to varying extents) consolidates the nuanced textures of the social contexts within which IPV patients live each day. Applying this line of reasoning, Bell and Mosher view medicalization of IPV as a process that could degrade the inherent individuality that characterizes this interpersonal issue. For instance, they state: “Medicalization is not simply the reduction of wife abuse to a biomedical label as a syndrome or a disorder. It is more aptly conceptualized as a complex process in which a social phenomenon becomes (re)constituted as a medical entity”\textsuperscript{247}. Critics like Bell and Mosher caution that as IPV morphs into a “medical entity” that orthopaedic surgeons are required to recognize and to respond to as part of standard patient care, appreciation for the individual circumstances of each patient’s case could be de-emphasized in the name of cultural change via attempts to get all orthopaedic surgeons to follow certain fundamental steps in practice (as a modality like an IPV check list would require). Fundamentally, though, this view carries with it the

\textsuperscript{246} Ibid. 215.
\textsuperscript{247} Ibid., 218.
assumption that a standardized protocol for IPV screening and response would limit orthopaedic surgeons’ abilities to tailor care to individual patients and thus would restrict orthopaedic surgeons’ autonomy to determine when screening is appropriate and necessary and how to go about conducting these encounters on a case-by-case basis. This assumption may not prove to be true.

This reconceptualization of IPV as an orthopaedic medical phenomenon—Step 2 in the medicalization of IPV—involves a process by which orthopaedic surgeons describe (and circumscribe) in a concrete manner what IPV looks like in their clinical practices—a patient’s intimate partner answers questions without the orthopaedic surgeon’s prompting, for example—and how to handle it—a patient is connected with appropriate community resources, like a family violence shelter, and then is followed up with weekly for two months to ensure continuity of care, for instance. In this process, analysts like Bell and Mosher contend, physicians and surgeons enter new roles that they may not be apt to fill given the reality that “curing” a human condition like IPV involves various types of interventions to resolve the effects of diverse issues like male-dominated culture, socioeconomic inequality, psychological control, and many more. If the medicalization of IPV occurs without the appropriate training of orthopaedic surgeons to play their
new roles as IPV identifiers and responders—as patient advocates—then patient care for victims of violence and abuse could actually devolve in a negative manner rather than evolve in a positive one. Bell and Mosher point out that “[m]uch of the literature now tells these physicians that they can, indeed, put abuse into a medical model; that they can diagnose it, treat it, and even end it”248. In medicine, physicians and surgeons are trained primarily to diagnose, treat, and cure—the role of physicians and surgeons in modern society is clear: they (should) alleviate problems. This culture clashes with realistic expectations of managing complicated social issues like IPV that require multidisciplinary approaches to healing; alleviating IPV from a patient’s life does not happen with the prescription of a pill or with the administration of a procedure in one patient-doctor interaction. Recognizing this dynamic, Bell and Mosher caution that medicalization of IPV carries the risk of oversimplification, of reductionism that gives physicians and surgeons a false sense of security (or of confidence) that their role in IPV intervention is curative, that they have the power and the abilities to enter an IPV patient’s life and fix the problem. Bell and Mosher state: “[A]ttempts to shape medical responses to woman abuse by treating it as a medical entity to be diagnosed and treated potentially occlude the social and

248 Ibid. 220.
structural roots of violence against women […]”249. These concerns about medicalization reducing IPV to an “entity” that can be diagnosed and treated by physicians and surgeons generate a fundamental question—and a theme—that defines this history: What is the role of a healthcare professional, such as an orthopaedic surgeon, in the care for an IPV victim? Is this role a counselor? Is this role a healer? Is this role a mandated reporter and/or a legal advocate?

Many questions about orthopaedic surgeons’ roles in society emerge from this theme, so it provides a fruitful lens for examining medicalization in general. If, instead of expecting physicians and surgeons to “cure” IPV in their patients’ lives (as if IPV were a type of social cancer that could be excised or eradicated and pushed into remission), society and the healthcare system expected them to play defined, niche roles in the larger consortium of efforts to deliver social justice to victims of violence and abuse, then carving out what those roles looks like in different medical settings is the logical next step. Taking this position and embracing this reasonable expectation, Zillmer views this defined niche as follows: “I think there are things we can teach orthopaedists about communication and how to most effectively communicate with these patients. As orthopaedists, we like to cure things—we like to fix things—

249 Ibid. 221.
and this of course is not a fixable problem. But, if we
demystify it to some extent and make it doable—we make
recommendations about what people should do, and we
make resources available—it becomes something more
manageable, and I think that people might then extend
themselves a little bit more”\textsuperscript{250}. This statement captures the
spirit of the medicalization of IPV in orthopaedic surgery that
leaders like Zillmer hoped to achieve. In short, as the history
of the medicalization of IPV in orthopaedic surgery has
already shown, orthopaedic surgeons like Bhandari and
Zillmer have worked to create tools, resources, and standards
of care that orthopaedic surgeons could use to grow their
knowledge bases on this topic and could implement in
practice to respond more appropriately to IPV victim
patients.

However, not all orthopaedic surgeons have agreed
with this medicalization of IPV spirit. In fact, both Zillmer
(in the United States) and Bhandari (in Canada) have faced
considerable resistance from their colleagues who have
contested the medicalization of IPV. In parallel, during the
past decade, Zillmer and Bhandari both led efforts to develop
position statements for their national orthopaedic
associations. First, at the turn of the twenty-first century,
Zillmer, as a leader of RJOS, stepped up to lead a task force

\textsuperscript{250} Zillmer DA. Personal interview. 27 June 2012.
on Family Violence. About this pioneering project, she recounts the following: “We worked with the American Academy of Orthopaedic Surgeons (AAOS), and we developed a position statement. It was interesting that, when we took the proposed position statement to the Academy’s leadership, to the committee that had to sign off on it, there was overt hostility by at least a few members at the table.”\footnote{Ibid.} These (visceral) negative reflex responses by Zillmer’s AAOS colleagues demonstrated at the time that some orthopaedic surgeons contested the medicalization of IPV; and, some did so vehemently, perhaps revealing some characteristics about the culture of orthopaedic surgery. Commenting further on this initial pushback, Zillmer adds, “I will say that this was looked at as an issue that didn’t have much to do with orthopaedics—why did we have to bring this up. There were some surgeons who didn’t want any part of it.”\footnote{Ibid.}

Then, a few years later—like Groundhog Day—Bhandari received similar protests from his colleagues when he led a parallel effort in Canada to establish an IPV position statement for the Canadian Orthopaedic Association (COA). Bhandari recalls, “At the time (around 2006 or so) we published our first paper on IPV in orthopaedic surgery, we approached the Canadian Orthopaedic Association (COA)
Board, and we pitched to them that we need to create a position statement through our national society that helps us understand what the roles of orthopaedic surgeons are”\(^{253}\). In approaching the COA, Bhandari’s motivation stemmed from more than just his personal opinion as a clinician; his research findings strongly shaped his thinking about IPV dynamics in orthopaedic settings: “I believed from the research we were doing at that time in 2006 that there was a real issue here and that surgeons should get more training on this issue because we have a real opportunity to make a change for health”\(^{254}\).

For Bhandari, the medicalization of IPV in orthopaedic surgery was an opportunity to intervene positively in patients’ lives. Yet, some of his orthopaedic surgery colleagues in Canada, like Zillmer’s in the United States, did not agree with the medicalization of IPV in their surgical specialty. In fact, Bhandari remembers that “[t]here was a uniform concern and a uniform feeling that this wasn’t a surgeon’s issue. They felt that we were opening up—I remember one person saying—‘a can of worms that we may not want to get into right now.’ That was the debate”\(^{255}\). Bhandari’s experience further illuminates the fact that some orthopaedic surgeons perceived IPV as strictly a social issue, not as a medical issue with musculoskeletal and other pertinent health implications.

\(^{253}\) Bhandari M. Personal interview. 27 June 2012.  
\(^{254}\) Ibid.  
\(^{255}\) Ibid.
Thus, screening for and responding to IPV did not fall within their purview, within their expected scope of practice. Succinctly, Bhandari summarizes that “[t]here was a considerable degree of concern and worry that this really isn’t our issue and why are we delving into something that’s really more a social services issue than a surgical issue”\textsuperscript{256}. In memorable ways, the hurdles that Zillmer and Bhandari have faced distill the controversial evolution that medicalization generates: When a social phenomenon evolves into a public health and then into a medical entity, expectations of physicians and surgeons change dramatically, which shifts their roles in society, alters their professional responsibilities as clinicians, requires of them the development and application of new skill sets, and, as a result, all of these changes combine to generate a need for updated and enhanced education and training. Recognizing this cascade, some physicians and surgeons contest medicalization, attempting to maintain the status quo with respect to the social phenomenon, such as with IPV.

When medicalization of IPV does occur, as it has in the United States and in Canada since the 1970s, it is valuable to examine assumptions that underlie the process and to appreciate the associated training needs in order to shape its trajectory in the best interest of the patient. To this end, Bell

\textsuperscript{256} Ibid.
and Mosher highlight the importance of educating and mentoring physicians and surgeons who are training amidst this change. They conclude that “[a] responsible standard of care employed by a medical practitioner needs to be learned in an environment where attitudes and values are critically examined and discussed, where experienced mentors can respond and model approaches” 257. If medicalization of IPV endows physicians and surgeons with the responsibility to screen for (diagnose) and respond to (treat) this new healthcare entity, then medical training must transition simultaneously and must embrace this expanded scope of practice in a timely manner so that the medical workforce is properly prepared to live up to the new professional standard that society now expects of it. For instance, if members of society and the healthcare system assume that physicians and surgeons are already empathetic enough to advocate for victims of abuse, this assumption could block efforts to teach physicians and surgeons at all levels of experience and of training specific skills for providing compassionate and effective care for IPV victim patients. Appreciating these training needs, Bell and Mosher and others who have analyzed physicians’ and surgeons’ preparedness to play healing roles in IPV victims’ lives argue that more education

is needed. Why is this the case? It is the natural, to-be-expected result of a mismatch in the rates of two processes: in essence, the medicalization of IPV has occurred at a much faster rate than has the creation and implementation of requisite training programs and practice tools for current and for future physicians and surgeons. To illustrate this knowledge gap, Bell and Mosher point out the deficits in how physicians and surgeons (and other HCPs) have communicated about IPV: “[T]he language, theoretical positioning, and ‘management’ vernacular in protocols, guidelines, and professional journals frequently ends up overtly and covertly portraying women as victims. They commonly lapse into paternalism, giving directions that suggest there is only a single, appropriate course of action—‘direct her to call the police’”\(^{258}\). In part, this type of paternalism stems from the traditional medical model in modern professional Western medicine that expects physicians and surgeons to alleviate—to cure—patients’ problems. When an issue like IPV becomes a medical entity, physicians and surgeons (and other HCPs) start communicating about it by applying the mental models that they have developed for approaching other conditions of human health and disease. If they apply mental models to IPV that do not account for its social and cultural

\(^{258}\) Ibid. 227.
complexity—if, for example, they conflate mental models applicable to the treatment of bone fractures with ones for the healing of fractured souls—then they could miss the nuances that characterize IPV victims’ unique situations—*their n of 1 constellation of signs and symptoms*. As a consequence, this type of conflation error could result in the lapsed judgment that Bell and Mosher warn about.

Clearly, this IPV knowledge gap presents an educational challenge. Commenting on the use of protocols as a modality for skilling physicians, Bell and Mosher state the following: “Through their reliance upon the medical model, [protocols] promote therapeutic and biomedical, not feminist, understandings of, and insights into, abuse and, in so doing, promote the medicalization of wife abuse. They treat women as a generic category of persons, and abuse as a ‘simple’ matter, and in so doing fail to attend to the complexities of women’s lives”259. When medicalization of IPV outpaces educational adaptations to train physicians and surgeons appropriately, then modalities are needed to bridge, and then to eventually close, this newly formed knowledge gap. This transition, however, does not happen all-of-the-sudden in most instances (save for the passing of a new law, such as a mandate that requires all physicians to report all abuse cases);

259 Ibid. 228.
instead, it happens diffusely over time, permitting time to play catch up.

_Closing the knowledge gaps:_ During this shift, current physician and surgeon leaders who champion IPV awareness, response, and advocacy—advocates who embrace IPV medicalization and its implications—face a conundrum: How best do I help expand and enhance my colleagues’ skills so that they can adequately live up to the new expectations that medicalization of IPV requires of them? In practice, there are many levels for educational intervention: (1) medical education; (2) resident training; (3) fellowship training; (4) continuing education; and, (5) professional research and communication. For instance, one could compose an op-ed in the _Wall Street Journal_; or, alternatively, one could help reform a medical school’s curriculum to include a special course on care for abused patients—many creative options exist. In a specialty like orthopaedic surgery, an orthopaedic surgeon who recognizes a need for better training about IPV could work through all five of these avenues in hopes of bridging knowledge gaps.

_The ‘chicken or the egg’ question:_ Initially, the most immediate concerns and attention would focus on existing clinical care practices since these actions impact patients’ lives presently. As an orthopaedic surgeon serving as an IPV educational leader in this situation, one would need to
recognize the aforementioned cautions; that is, one would need to be mindful of and hedge against the biases, assumptions, and attitudes that other orthopaedic surgeons may currently hold as a result of the social, cultural, and professional forces that have molded their mental models about IPV prior to its medicalization in their specialty. Herein lies a ‘chicken or the egg’ question: Does changing orthopaedic surgeons’ behaviors alter how they think about IPV; or, does changing how orthopaedic surgeons think about IPV alter their behaviors. If one were an orthopaedic surgeon concerned about improving care for abused patients, and one believed that orthopaedists needed to behave in certain ways to achieve better outcomes, one could consider this ‘chicken or the egg’ thought experiment while determining how best to lead his or her peers.

Making this thought experiment explicitly personal, if I held—which I do—the belief that changing orthopaedic surgeons’ behavior is a pre-requisite step to changing their attitudes, thoughts, and feelings about IPV, then I would be motivated to create and to implement modalities—like evidence-based screening protocols—that would alter how my peers acted in clinical practice. Through actions, I would contend, is the best way to change physicians’ hearts and minds; though, justifying the need for such actions requires rigorous evidence and rational logic. For example, I could
craft and then test a clinical algorithm for screening for and responding to IPV in orthopaedic trauma settings specifically. In application, this research process could result in a simple yet effective concrete product: an easy-to-navigate digital form embedded in the electronic medical record system that features a step-wise process and a framework that orthopaedic trauma surgeons could use to screen all patients for abuse-related injuries. In theory, regardless of the individual physicians’ personal attitudes and beliefs about IPV, this step-by-step tool could enable all orthopaedic trauma surgeons to provide a baseline acceptable standard of medical care.

In practice, this approach to influencing orthopaedic surgeons’ behaviors strikes at the tension between standardization and individualization. The balancing of this tension raises even more questions: Is this type of protocol a “boiler-plate” or a “cookbook” approach to caring for IPV victims? Does this “medical model” dehumanize IPV? Does it turn patients’ diverse IPV conditions into a single entity that orthopaedic surgeons can treat in a simplistic, perhaps straightforward, manner? Does such a protocol grant orthopaedic surgeons enough provider autonomy to adapt

care plans in manners that accommodate patient individuality respectfully? To be sure, the answers to these questions depend on many factors, including, perhaps most importantly, how well designed these clinical tools are in the first place. Devising useful tools requires tests, revisions, and validations: it requires research into how best to balance this standardization versus individualization tension. Thus, as an orthopaedic surgeon interested in influencing positively and constructively how my colleagues view and respond to IPV, I would be motivated to conduct research studies on IPV, inquiring about topics that range from the epidemiology of fracture patterns to the effectiveness of different screening tools in clinical practice. In time, this type of empirical work could influence how orthopaedic surgeons perceive IPV as a medical entity, which could potentially alter their behaviors as healers positively.

This ‘chicken or the egg’ thought experiment elucidates the reality that knowledge gaps arise when medicalization outpaces training. In turn, these gaps expose physicians and surgeons as vulnerable people, as humans who do need assistance when it comes to practicing the art and the science of healing their fellow human beings. Physicians and surgeons caught in IPV medicalization knowledge gaps either struggle to respond appropriately to victims of abuse— because they lack the skills necessary to do so but are still
expected by society to serve in this capacity—or, alternatively, manage, and perhaps eventually gain competence, by utilizing supportive resources that help them think and act in new ways. Since the latter demands behavioral change, currently practicing physicians and surgeons caught in knowledge gaps could change their behaviors through self-education. Building on the discussion of protocols as an example modality, experimenting with protocols provides practicing physicians and surgeons with a method for self-education: this process gives them tools to test out in clinical practice to learn about how others with more experience managing this medical situation approach patient care. Real-world experiences—clinicians’ lessons learned from trial and error—are hopefully embedded in these algorithmic protocols. This type of framework reflects a mental model, and a physician or a surgeon interacting with this mental model could implement it as an aid for approaching IPV in new, constructive ways. In time, this physician or surgeon could also evaluate this tool empirically for validity, which could initiate an ongoing process of self-discovery that could be shared with the rest of the orthopaedic surgery community.

Thinking more about protocols: Ideally, IPV protocols-
developed using the guidelines that Sprague et al.\textsuperscript{261} outlined recently could help bridge knowledge gaps as orthopaedic surgeons educate themselves about IPV and its clinical manifestations and management. As part of this process, these surgeons would then develop their own personal approaches to screening and response using these tools, informed by the shared insights of other orthopaedic surgeons. As the next step, this process of sharing IPV care insights and experiences among the orthopaedic community is paramount to breaking the relative historical silence on IPV in this specialty. In fact, Bhandari observes that many orthopaedic surgeons do not overtly avoid discussing IPV but instead feel unequipped with the tools and skills necessary to manage it: “Most surgeons are actually quite, I would say, somewhat shy to even bring up the topic because they don’t even know where to begin”\textsuperscript{262}. If, for instance, a practicing orthopaedic surgeon with insufficient training previously on IPV were able to apply an IPV clinical protocol in his or her office and were able to identify an abuse-related injury and to respond appropriately, the care and support for victims of abuse in the healthcare system would improve overall because


\textsuperscript{262} Bhandari M. Personal interview. 27 June 2012.
this specialty-specific intervention would expand the total number of channels available for IPV patient advocacy and outreach in society.

However, this perception of “improvement” implies fundamental assumptions: namely, that orthopaedic surgeons’ responses to these IPV victims are both warranted and appropriate. The assumption that they are warranted represents the initial medicalization dilemma: Is IPV a human condition that medical professionals should identify and respond to in the first place? Answering “Yes” to this question sets in motion a medicalization of IPV process. From there, the question of what is appropriate management of IPV—“diagnosis” (awareness) and “treatment” (response)—in specific clinical settings rises to the surface as most critical to ensuring high quality patient care, to optimizing the trajectory of Step 2 in the medicalization of IPV. In answering this question, defining “treatment” in orthopaedic surgery settings could include referring patients to local community resources, such as family justice centers\textsuperscript{263}—an educational or a patient-navigator role—or it could mean something more involved, such as creating a plan with the patient about how to escape the abusive relationship safely and what to do when issues of safety arise in the

future—perhaps more of a counselor or an informed-advocate role. In each medical specialty (and sub-specialty), this evaluation of appropriate treatments will lead to varying tangible conclusions (a hallmark of the Clinical Medicine stage of the medicalization of IPV): some may view appropriate response as ensuring the patient escapes the abuser completely, reaching full safety safely; alternatively, others may limit the definition of appropriate treatment to listening empathetically to a patient during an office visit when the patient elects to disclose about violence or abuse. Listening, in and of itself, is healing. These (inherently necessary) variations and gradations in defining appropriate IPV responses and in describing what treating IPV actually means in practice convey the complexity and the uncertainty that characterize IPV knowledge gaps. This uncertainty cannot be defined away.

Localism: One response to this variability is to localize understanding and expectations. Embracing localism in medicine, Bhandari explains the importance of orthopaedic-specific IPV information: “The reality is that surgeons are highly influenced by and highly interested in information that’s relative to them; they are less interested in information that is based on family practice or on obstetrics and gynecology or on the emergency department, which doesn’t directly relate to what’s happening in the clinic to an
orthopaedic surgeon”264. Accounting for this need, the creation and implementation of specialty-specific protocols (as discussed earlier via thought experiment), serves as a mechanism for localizing IPV knowledge because efforts to figure out in concrete, practical ways how best to screen for and respond to IPV in orthopaedic settings illuminate the nuances of how this human condition manifests amidst care for musculoskeletal health. Here, it is important to recognize that, as Zillmer shares, “[w]ith elder and child abuse, it’s quite easy: you find your state statute on responsibilities and reporting and follow the guidelines. But what to do for a victim of IPV is not well defined or regulated unless there has been gun violence or life threatening injury. We are therefore left on our own to decide what to do. Becoming educated on this very relevant orthopaedic topic can serve to guide us”265. Similarly, according to Bhandari: "We have a pretty good understanding and a pretty good legal paradigm that suggests that if a child comes in under the age of two, un-witnessed, with a long-bone fracture, there is a series of events that must take place. For the most part, almost every surgeon has that alert on when that happens”266. As Zillmer and Bhandari both recognize, an orthopaedic-specific knowledge gap in the care for victims of violence and abuse is the fact that orthopaedic

264 Ibid.
265 Zillmer DA. Personal interview. 27 June 2012.
266 Bhandari M. Personal interview. 27 June 2012.
surgeons are accustomed to following standards of care for help in handling child abuse cases but do not commonly follow such protocols as aids in managing IPV patients’ cases currently. In what ways do established standards of care for handling child abuse cases help orthopaedic surgeons at the bedside and in the clinic? Bhandari describes the process of applying a child abuse protocol like this: “Your decision-making follows a routine pathway that’s become second nature. It’s done with no particular malice towards any of the parents. This is simply a procedure that is done; the parents understand that it’s going to be done; it’s there to protect children. The challenge is that the laws and regulations and policies pertaining to adults are far less regulated.”

Taken together, these comments by Zillmer and Bhandari indicate that orthopaedic surgeons could potentially benefit as clinicians if they were to approach IPV in a manner more similar to how they have handled child abuse historically.

Learning from child abuse advocacy: For several decades, orthopaedic surgeons have researched and published about fracture patterns in children. Insights gained from these inquiries have informed and improved care. Intending to do the same for the care of IPV victim patients, about a decade

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267 Ibid.
ago, Zillmer crafted resources for orthopaedic surgeons: “As outlined in the article we wrote about a toolbox for orthopaedic surgeons, there are fracture patterns and certain facts that are important to know about, such as how to speak to someone who is a victim of intimate partner violence and how to obtain information and then what to do with that information”\textsuperscript{269}. To make IPV responses more similar to current child abuse care in orthopaedics, these fracture patterns and “how to” tips could be embedded into the algorithm of a standardized IPV protocol. If this algorithm included evidence-based steps that walked orthopaedic surgeons through a process of evaluating fracture location, severity, and associated characteristics in conjunction with other aspects of the patient’s presentation (bruising as a physical exam finding, for example), then this protocol could apply localized IPV knowledge to aid orthopaedic surgeons at the point of care. Of course, Zillmer recognizes the aforementioned reductionism concerns and offers the following advice on how to hedge against this natural tendency: “We need to not just be concerned about the fracture; we need to be concerned about the etiology of the fracture, or the etiology of the problems that we treat. And prevention, if possible, needs to be part of what we do. We need to be interested in how the patients got to us, not just

\textsuperscript{269} Zillmer DA. Personal interview. 27 June 2012.
the fact that they’re in our emergency room or in our office”270. This perspective conveys how an orthopaedic surgeon could balance the tension between individualization and standardization in practice by using a protocol as a tool for investigating fracture etiology thoroughly. In practice, Zillmer asserts that it is important to keep an open mind while engaging in protocol-directed behaviors: “We need to be inquisitive so that we don’t misdiagnose these fractures, and we need to present that from the beginning to medical students and to residents so that they don’t just become recipe followers, and they remain inquisitive about the injuries and conditions that we treat”271. Overall, Zillmer’s thoughts indicate that, if skilled properly on how to stay inquisitive while using IPV algorithms, orthopaedic surgeons could follow (as Bhandari described about child abuse care) “a routine pathway that’s become second nature” to care for IPV victims appropriately, just as they have done in diagnosing and treating child abuse patients for decades.

*It starts with skilling:* Ultimately, in order to implement, study, and share experiences with IPV protocols—as mechanisms for harnessing medicalization in patients’ best interests—training and continuing education on how to interact with such guides should also occur. According to Bell

270 Ibid.
271 Ibid.
and Mosher, “First, it is clear that protocols—even those that resist medicalization, and so on—will not effect much positive change in the hands of a person unskilled in using them. Thus, a crucial piece of work to be done is the ‘skilling’ of physicians”\textsuperscript{272}. So, even if orthopaedic surgeons collaborate to create an evidence-based protocol that recognizes and accounts for the negative aspects of medicalization by including steps in the algorithm that accommodate diverse IPV patient needs, they would need to also pursue avenues for “skilling” their colleagues at the same time. As one option, this type of skilling could occur through publishing; orthopaedic surgeons could study IPV issues in orthopaedic settings and then could publish the results in the orthopaedic journals, sharing insights gained empirically, as Bhandari, Della Rocca, and others have done with increasing frequency recently. Alternatively, orthopaedic surgeons could work with their national association, such as the American Academy for Orthopaedic Surgeons (AAOS) or the Canadian Orthopaedic Association (COA), to develop and deliver continuing educational courses and resources on IPV. These efforts targeted at current orthopaedic surgeons could hopefully close the IPV knowledge gaps while serving as stopgaps: orthopaedic surgeons’ IPV knowledge would increase to

catch up with the expectations that medicalization has created.

At the same time, changes in orthopaedic surgical practice could also influence fellowship and residency training via a trickle-down effect. When orthopaedic surgeons in practice start openly talking about and working on IPV issues in their specialty specifically, IPV morphs into an aspect of medical care—a medical entity—that future orthopaedic surgeons must be prepared to handle professionally. In turn, orthopaedic mentors in fellowship programs and directors of and instructors in orthopaedic surgery residency programs may recognize this new training need and could respond by carving out formal time and space to teach about IPV. Interventions at the training level have a lasting, potentially transformative impact. In fact, Zillmer recalls residency as the time when her awareness of IPV crystallized: “[I]t was my experiences as a resident in the Bronx that brought [IPV] home more as an important medical issue”\(^{273}\). Likewise, while he was aware of IPV as a medical issue during his medical school studies in the early 1990s, Bhandari first recognized during his fellowship training an opportunity in orthopaedics to improve patient care: “I think it really resonated and became clear to me that there was an opportunity for us to be doing more in the field that I am in, which is orthopaedic

\(^{273}\) Zillmer DA. Personal interview. 27 June 2012.
surgery, around 2003. And that was during my Trauma Fellowship at the University of Minnesota”

At some level, curricula for resident and for fellowship training in orthopaedics are adapted to match the demands of orthopaedic surgical practices at the time, evolving over time. Therefore, if medicalization of IPV in orthopaedic surgery leads to changes in orthopaedic surgeons’ standard clinical behaviors, then this shift in practice could translate into accompanying alterations in orthopaedic surgery residency and fellowship programs’ pedagogies.

To further assist this cause, orthopaedic surgeons who champion IPV education reform could work directly with orthopaedic surgery fellowship and residency program directors to shape pedagogy in ways that better match the evolution of care occurring in practice. For instance, one resident- or fellowship-level teaching modality could be a required clinical rotation with local IPV projects and/or organizations, modeled after the hands-on experience that influenced Bhandari’s fellowship training significantly: “I was doing fracture care work [during my fellowship], and I got connected with a program there called the Minneapolis Domestic Abuse Project, working with their Director of Therapy, Dave Mathews. We were able to do quite a bit of

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274 Bhandari M. Personal interview. 27 June 2012.
work together, and that was the spark that ignited a pretty significant flame going forward276. Like Bhandari, as orthopaedic surgery residents and fellows experience IPV training in the field, they would graduate to clinical careers more aptly prepared with the skills necessary to meet the expectations that medicalization of IPV generated by expanding the scope of orthopaedic practice. Lastly, intervening even further down the hierarchy of orthopaedic education, orthopaedic surgeons could also inform medical education as another method for skilling future orthopaedic surgeons.

What about legal remedies? Beyond education, some leaders could look to legal interventions as tools for optimizing the medicalization of IPV in orthopaedic surgery, invoking Justice stage dynamics of IPV’s tripartite history. In assessing the justice landscape for places to plant seeds, Zillmer is hesitant about pursuing this route: “I don’t think in this specific setting that regulations are what we need. People push back against regulations, and I think this is one of those areas where you want buy in; you don’t want pushback”277. Instead of instituting new regulations, Zillmer advocates for investing resources in education: “I think we would be better off starting with educating the medical students so that they

276 Bhandari M. Personal interview. 27 June 2012.
277 Zillmer DA. Personal interview. 27 June 2012.
become comfortable with these issues, and it becomes part of a person’s normal approach to practice as a thing we have to be aware of and to think about. […] Start with education to those most flexible in their thinking—the most open to learning—and that would be medical students and the residents. So we need buy-in from the academic centers that this is important so that teaching will take place. Like Zillmer, Bhandari is cautious as well about regulatory approaches, especially about mandating responses to IPV legally: “[S]ome argue that having a mandatory screen causes some woman to close off, and so creating a mandatory pathway may be more harmful than good. … In fact, women are at more risk of being harmed at the time they disclose, so therefore I think surgeons in many ways don’t feel prepared or at all comfortable with moving in any one particular direction. But part of their thing is what do we do? And so the laws haven’t really been there to say what they’re supposed to do.” Instead of relying on legal force to achieve compliance, Bhandari, Zillmer, and other orthopaedic surgeons who champion screening for and responding to IPV believe that changing orthopaedic culture and its professional norms from the inside out is the best approach and is best achieved through research, communication, education, and

278 Ibid.
279 Bhandari M. Personal interview. 27 June 2012.
collaboration. In this envisioned intellectual environment—which appears to have coalesced with exponential growth over the past decade—more and more orthopaedic surgeons would only implement a standardized protocol for IPV care if it actually proved useful in real-world practice. With these goals of practicality and functionality in mind, Bhandari shares his motivations and intentions as an IPV advocate: “All we are trying to do, quite frankly, is create awareness and create a safe environment for women to disclose, and, at their discretion and at their want, helping them find a path forward, whatever that path may be. We are not here to tell them to leave; we are not here to tell them what they’re supposed to do. We’re simply trying to get surgeons to be empathic to the reality that some women who come in with injuries may in fact have suffered them from intimate partner violence and to be aware of and sensitive to that issue. In Bhandari’s view, medicalization of IPV in orthopaedic surgery involves raising awareness about this issue through leadership, research, communication, and training; it does not involve overtly forcing orthopaedic surgeons to all behave the same way in caring for IPV victims. Instead, he has enrolled his orthopaedic colleagues in his noble vision to improve IPV awareness, response, and advocacy by engaging them in both formal and informal conversations. Exploring standardization

280 Ibid.
In recent history, many aspects of medicine have benefited from standardization of care to improve patient safety and clinical outcomes. In fact, the current movement to improve safety and quality in healthcare systems is based on extensive research that demonstrates that standardized systems of care involving tools like checklists and other protocols/algorithms can improve medical care delivery substantially. For historical perspective, for a long time, physicians and surgeons did not think that it was necessary to implement an evidence-based, standardized procedure for placing central lines in patients. Clinicians possessed the full autonomy to place central lines as they saw fit. Today, physicians and surgeons now know that five simple steps, when arranged as a single protocol that is part of a cultural transformation process, improve patient care dramatically.

Perceiving a similar hesitancy to act, Loue shares that without formal attempts to change HCPs’ behaviors, IPV continues to occur in society because professionals fail to intervene responsibly: “Theory postulates that intimate partner violence occurs because we collectively permit it to occur, because of how we view women, because of our failure

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as a legal system to address and punish the violence when it does occur, and through the inability and/or unwillingness of many of our helping professions to recognize its signs and to intervene. While trying to intervene responsibly, Zillmer encountered this type of unwillingness to advocate when she tried to enlist her orthopaedic surgery colleagues in simple IPV outreach: “In my private practice experience, I was told that it was not going to be possible for me to post information [about IPV] in the women’s restroom—it just wasn’t going to be done in our practice—and those were senior partners, so that is how it was.” However, this resistance did not deter Zillmer; she was determined to reach out to her patients: “[M]y checkout person would pull out the cards that contained information about the local domestic violence resources in the community. So, these resources would be there, and the cards would sometimes disappear. I was able to display information as it related to me directly, but I was not able to use community space to display information.” Looking back, perhaps this resistance (another “force of silence”) that Zillmer faced in practice reveals something about the culture of orthopaedic surgery.

284 Zillmer DA. Personal interview. 27 June 2012.
285 Ibid.
Considering gender and orthopaedic culture: Perhaps, at some level, this historical resistance to IPV awareness, response, and advocacy in orthopaedic surgery has stemmed from the traditionally male-dominant culture of orthopaedics. Assessing this hypothesis, Bhandari recognizes that this gender imbalance could influence the perceptions and the treatments of IPV in this specialty: “Well, I think, historically—it’s not even historical since it’s still maintained today—because over 95% of the orthopaedic fraternity is male, it’s a male-dominated fraternity. I think, in many ways, there is a culture associated with that—with the maleness of the fraternity—which produces a grave level of discomfort with this issue”\textsuperscript{286}. One could argue, then, that female orthopaedic surgeons would be more concerned about IPV because the battered women’s movement emerged from the feminism movement or because more females suffer the negative health consequences of violence and abuse. Case in point: Zillmer and RJOS provided pioneering female leadership in advocating for IPV patients in orthopaedics before male surgeons like Bhandari took up the cause. At the present time, however, it is not possible to assess adequately whether, or to what extent, the male-dominant culture of orthopaedics has contributed to the historical silence on IPV in orthopaedic surgery. Instead, as Bhandari suggests, 

\textsuperscript{286} Bhandari M. Personal interview. 27 June 2012.
orthopaedic surgeons’ hesitancy around IPV may stem primarily from deficits in training, from knowledge gaps that have yet to be addressed: “It’s easier to marginalize an issue as social services than to actually take it on head on and realize that there’s a lot of work to do. The discomfort in dealing with it, when you get to the core of most surgeons, is not that they don’t want to help; it’s that they don’t even know what to do, so why begin”\textsuperscript{287}. From this view, any orthopaedic surgeon, regardless of gender, would be hesitant about delving into a complex issue like IPV without a proper educational foundation to draw on.

Turning the existing gender imbalance in the orthopaedic workforce into a positive, Bhandari and others perceive male involvement with IPV advocacy as important and needed. Bhandari explains: “I think part of it is that we need male role models. When you talk to the women who are in the IPV movement—whether they’re journal editors or a foundation president or involved with all these really wonderful organizations—they say it’s extremely powerful to have men involved in leading this charge. So what better area than orthopaedic surgery where we’ve got an overwhelming dominance of males who have a real opportunity to do something pretty special”\textsuperscript{288}. Agreeing with Bhandari, Zillmer

\textsuperscript{287} Ibid.
\textsuperscript{288} Ibid.
focuses on education as the answer when considering the gender discrepancy in the orthopaedic surgery workforce and its implications for IPV: “I think that certainly men have communication skills too, and I think that if we begin to emphasize that in our education system then we should get to the point where it really doesn’t make any difference”\textsuperscript{289}. That is, with the right training, both male and female orthopaedic surgeons alike can serve as leaders on and advocates for IPV victim patient care issues.

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\textsuperscript{289} Zillmer DA. Personal interview. 27 June 2012.
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Figure 1. Why the silence on Intimate Partner Violence (IPV) in orthopaedic surgery?
Figure 2. How to break the silence on Intimate Partner Violence (IPV) in orthopaedic surgery
Photo: Justice problem or public health problem?
Billboard (c1980s) Still standing in East Baltimore, Maryland reflects how older conceptions of IPV still permeate our culture