

Letters to the Journal

A Response to: “The USPSTF Recommendation on Intimate Partner Violence: What Can we Learn From It and What Can we Do About It?” (Article from Volume 1, Issue 1.)

Linda Chamberlain’s article along with the FVPF (Family Violence Prevention Fund) Research Committee’s review of the USPSTF’s (US Preventative Services Task Force’s) draft recommendation NOT to encourage doctors to routinely screen for family violence omits what in my opinion is the obvious reason why the USPSTF would make such a decision: The USPSTF is operating under an (allopathic) medical model (so-called “evidence-based methods” or EBM) for family violence screening whereas the FVPF’s research committee is operating under a behavioral assessment/social science or social work model. This leads to both groups speaking *different languages* to each other. The medical model speaks the language of (direct) cause and effect (take this pill and X happens), whereas the social science model recognizes multiple causes/effects (even if some may be spurious) that the medical model glosses over, and as such, seems to be more “vague” than the medical model.

The USPSTF seems to have borrowed heavily from the work of Harriet MacMillan and C. Nadine Wathen, whose articles in JAMA (2003; 289[5]:589-600) and CMAJ (09/16/2003; 169 [6]) are the definitive medical response to all the work that has been done in the field. They were the major architects of a 62-page Canadian study completed in September 2001 (available in online PDF from the Canadian Task Force on Preventative Health Care [CTFPHC] at

www.ctfphc.org), which uses EBM to come up with its conclusions.

EBM seems to be the means by which researchers or health policy makers come up with a “formula” to decide if you are sick, what illness you have, and how to treat said illness. It allows little in the way of ‘creativity’ – i.e., if you don’t meet their criteria for a certain illness, no matter what may be happening to you, they’ll assume “it’s all in your mind” and that “you’re not REALLY sick.” It also forces doctors to prescribe certain medications for certain conditions – even if a patient has an unexpected reaction (or “unintended consequence”) from said medications. This is “cookie cutter” medicine at its worst – and can frustrate both doctor *and* patient.

In terms of family violence, this prejudice caused by over-reliance on EBM reveals itself in a belief that “there are no studies showing the accuracy of screening tools for identifying family and intimate partner violence...” – which may be true after you look at close to 2200 references (as Wathen & MacMillan did for their JAMA article) and discard the vast majority of them (leaving only about 22), because close to 99% did not meet their narrow criteria for further study. These actions are, in effect, throwing away the proverbial baby with the bathwater on the subject of screening for family violence.

This fact should have set off alarm bells in the heads of JAMA’s peer reviewers for Wathen & MacMillan’s article – since MacMillan & Wathen rejected so many references as part of their research, their own article should have been rejected since their sources are

only about 1% of the original universe of references. In statistics, this is called using “outliers” to try to make a conclusion about the general population (of references on family violence in this case). This is **bad statistics** and perhaps **bad science**.

I became interested in this subject while compiling an annotated bibliography for a class in Sociological Analysis. In that pursuit, I used material from the year 2000 to the present to pick 10 articles on the subject of screening for family (or domestic) violence. There is one exception to this, however; I used an article involving medical coding (from 1997), since it was the only one I could find that analyzed domestic violence screening from the perspective of the medical biller or coder.

In the course of this work, I found far more than 22 articles on the subject that I could have analyzed scientifically than Wathen and MacMillan used for their whole article (and they searched databases from 1963 through 2002). Shouldn't these people have found (and used in their study) more articles than I did (allowing for cessation of their work in late 2002)? After all, I am an *undergraduate* Sociology/Anthropology student, and they are *professionals* in their field who should have access to more literature than I do.

As a result of my quick examination of EBM, I feel that it hurts patients rather than helps them: see for example the article “EBM: Unmasking the ugly truth” (BMJ; 2003[325]:1496-1498), which, while written as a satire (by two proponents of EBM under a pseudonym), cuts to the heart of the problem of EBM: it is subject to the prejudices of the ‘medical establishment.’ John Young’s article “Who

defines best treatment? Could it be accountants?” at www.dailysentinel.com for February 11, 2005 shows the logical conclusion of the adoption of EBM: in its present form, it leads to people WHO MAY NEVER SEE A PATIENT making up the treatment guidelines (type and length of examination, tests to be used, medications to administer, etc.) which is then dictated to doctors who do examine patients. This may be why lots of “old school” doctors don’t care for EBM or the HMOs that push it as a “cost-cutting measure.”

There is an additional irony in all this: while promoters of EBM (including Wathen & MacMillan) want additional “scientific” research on present methods for the prevention & treatment for domestic/family violence, where are their voices when a potential solution to this dilemma has been languishing in the US Congress for over two years? The bill originally called HR 1267 (and now VAWA HEALTH, part of the newly introduced Violence Against Women’s Act) calls for exactly what they (say they) want. So to the USPSTF, MacMillan & Wathen, etc., I urge all of you to support this bill so that there we can get some real answers — without excuses.

And as to those working with patients on a daily basis, *document* what you do (subject, of course to HIPAA [the Health Insurance Portability and Accountability Act]), so that you can show those doubters out there that *something* is being accomplished to reduce/ameliorate family violence with the *tools that already exist*.

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The views in the letters to the journal do not reflect those of the editor or the FVPPF.