

—Our experience with a multidisciplinary program involving law students and practicing lawyers into an emergency department suggests another measure that can be incorporated into the research and evaluation of interventions from affected patients. We obtain this information in the context of enhancing available services to women presenting on Friday and Saturday evenings. Our team provides assistance in obtaining emergency restraining orders against batterers directly from the emergency department without requiring the women to proceed out of the hospital to a police station or courthouse. In addition, we offer our injured or battered patients continuity of legal services by providing a lawyer from the same program to meet them in one of our courts the following business day to transform the emergency restraining order into a full 1-year protective order. The prevalence of women presenting with acute injury as a result of intimate partner violence closely approximates that reported by Dr Abbott and colleagues¹ and translates to one to three patients per evening shift. Therefore, our law students have ample opportunity to interview every patient available during their shifts.

The review is anonymous, and we invite all women queried about their own lives and those of other family members to participate if they know within their communities. The histories we receive are rich and varied. Thus far, two major themes have emerged from a qualitative evaluation of the study: (1) many women have found restraining orders to be successful in their attempts to leave battering relationships, and (2) many women have physically fought back their batterers to preserve their safety or make possible an escape.

Our law students leave the interviews with an enhanced appreciation of the intellectual acumen and the resilient dignity of our battered patients, many of whom are impoverished and disenfranchised, and these encounters become an important aspect of their education about future clients. Information about the effectiveness of interventions serves to support and sustain the efforts of the emergency department staff in their efforts to continue to intervene with domestic violence.

It is our hope that efforts to include the voices of patients' experiences would greatly enhance understanding of domestic violence. The use of qualitative research may significantly enhance public health efforts where more traditional quantitative evaluations are difficult or impossible to achieve.

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1. Abbott J, Kozdol-McLain J, Lewenstein SR. Domestic violence against women and prevalence in an emergency department population. *JAMA*. 1997;277:1027-1031.

—Throughout their report, the authors discuss domestic violence to women caused by a "boyfriend or husband." Although the women who were the subjects of this study were given a questionnaire that inquired about their marital status, the authors do not reveal the marital status of women subjected to domestic violence.

It may be a politically incorrect question to ask, but the authors could tell us what percentage of women who were battered by their boyfriends or husbands were also battered by their husbands.

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1. Abbott J, Kozdol-McLain J, Lewenstein SR. Domestic violence against women and prevalence in an emergency department population. *JAMA*. 1997;277:1027-1031.

In Reply.—One of the problems with domestic violence research is lack of a consistent definition, as Dr Donohoe points out. Since one of our major goals was to clarify statistics reported by others and widely cited in debates about public policy, we tailored our definition to include both physical injury and emotional intimidation, as other studies that we cited had done, but did not include either sexual violence or childhood abuse. Pregnant patients were included. In our study, 42 women (7%) were pregnant, and another 52 (9%) were not sure if they were pregnant. The rates of acute domestic violence, recent domestic violence within 1 month, or cumulative prevalence of domestic violence did not differ statistically between pregnant and nonpregnant patients.

We agree with Dr Herbert and Ms Kanter that personal counseling by a legal team physically present in a busy emergency department would certainly be expected to enhance a woman's feeling of support at the time she encounters the medical care system. The correct responses for keeping women safe and healthy while addressing domestic violence are not yet known. Medical recognition and diagnosis are the first steps. Such innovative work is clearly needed to help us all answer the next pressing question: "What is the best way to respond when we as physicians make the diagnosis of acute or recent domestic violence?"

We chose not to report rates by marital status because of the ambiguity in reporting between "married," "divorced," or "separated." We did, however, collect that data. There was no difference in marital status for acute domestic violence or 1-month-period prevalence. However, for cumulative prevalence, domestic violence rates varied significantly around an overall rate of 54%: single (45%, n=122), married (52%, n=163), living together (63%, n=81), divorced (65%, n=136), separated (73%, n=56), and other (widowed, etc, 34%, n=88). Thus, the risk of ever having experienced domestic violence was greater among women who were separated, divorced, or living together, but not married at the time of the study. Unfortunately, we cannot answer Dr Schaffly's exact question, since we did not ask about marital status at the time of remote domestic violence. However, it was of great interest to us that only 31% of women who reported ever having experienced domestic violence were currently in an abusive relationship.

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Geriatric Psychiatry and the Limits of MeSH

To the Editor.—The review of the *American Journal of Geriatric Psychiatry* by Drs Bowden and Long¹ is positive about the scope and contents of this new journal, now in its third volume. However, the review goes on to state that there were fewer than 120 articles with the subject heading of *geriatric psychiatry* in MEDLINE for 1990 through mid 1994 and concludes that "the number of articles published thus far does not provide convincing evidence that the need exists for another highly specialized journal." We feel an obligation to point out that the methods used to estimate the number of published articles in this field were incorrect. According to the MEDLINE scope note, the MeSH heading *geriatric psychiatry* refers to "a subspecialty of psychiatry concerned with the mental health of the aged" and that it is "not for mental disorders in the aged"; thus, the heading is used to index articles related to the profession and subspecialty area, not to the disorders and treatments that represent the foci of its clinical activities and research.

To understand how this affected the conclusions presented in the review, we conducted several additional MEDLINE searches. For the period from 1991 to mid 1995, MEDLINE lists 170 articles under the subject heading *geriatric psy-*

When the ACAS was initiated in 1985, arteriography had a high complication rate, ultrasound imaging was not well developed, and there was negative sentiment regarding carotid endarterectomy because platelet antiaggregating agents were thought to suffice. Our study reflects these constraints because, once initiated, the ACAS could not be restructured.

Dr Foster misunderstands the statistical methods used for contrasting the results of medical with surgical management. When the Monitoring Committee determined that ACAS stopping boundaries had been crossed at a median (not mean) of 2.7 years, our follow-up exceeded 3 years in 44% of patients and 4 years in 26% of patients, and 9% of patients had exited the study at 5 years. Cumulative 5-year event rates were estimated using the Kaplan-Meier procedure in which each patient contributes data only for those intervals for which he or she was observed; no "extrapolation" is involved. Similarly, NASCET was unblinded at 18 months and Kaplan-Meier estimation processes also were used.

We are as pleased as Dr Goldstein that an evidence-based study has demonstrated that medical management of carotid stenosis is efficacious. The Asymptomatic Carotid Artery Progression Study,¹ which was conducted by a subset of ACAS investigators, showed that risk factor modification and intervention with lipid-lowering agents can limit lesion progression and perhaps cause plaque regression in some, but not all, instances. For those patients in whom the carotid lesion progresses, the ACAS data suggest carotid endarterectomy to be another option.

Regarding the health care policy implications raised by Drs Oddone and Waters, we urge that quality control measures for the entire medical-surgical team, including validation of ultrasound laboratories, become the benchmark. How to identify patients who should be considered² at excess risk for stroke and for complications will be considered in future publications. We were disappointed that we were unable to stratify reliably noninvasive tests by degrees of stenosis using Doppler ultrasonography.

The ACAS group has demonstrated that in contrast to emergency management after transient ischemic attack or partial stroke, elective carotid endarterectomy is a better choice for some patients. We disagree with those who trivialize our results by labeling some strokes "minor." From the patient's viewpoint, all strokes are major. The risk of stroke can be reduced by good health habits, stringent risk factor reduction, and, in some instances, carotid endarterectomy. There are no compelling data demonstrating that aspirin prevents progression of carotid stenosis.

We suggest that carotid endarterectomy be performed only on a subset of asymptomatic patients based on age, concomitant risk factors, progression of disease, and overall medical status of the individual in an institution where a proven record of safety approaching that of the ACAS surgeons has been demonstrated. Alas, to achieve this, physicians must continue to use clinical judgment and be on the alert to maintain quality in their institutions and among their colleagues.

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1. Furberg CD, Adams HP Jr, Applegate WB, et al. Effect of lovastatin on early carotid atherosclerosis and cardiovascular events: Asymptomatic Carotid Artery Progression Study (ACAPS) Research Group. *Circulation*. 1994;90:1679-1687.
2. The European Carotid Surgery Trialist Collaborative Group. Risk of stroke in the distribution of an asymptomatic carotid artery. *Lancet*. 1995;345:2209-2212.

Domestic Violence Against Women

To the Editor.—Dr Abbott and colleagues' report that while the lifetime prevalence of domestic violence among women

visiting an emergency department is quite high, 54%, the incidence of acute domestic violence, 11.7%, is significantly lower than was found in previous studies. However, the authors' methods of eliciting information on domestic violence may have led to an underestimate of both values.

The authors excluded women younger than 18 years; yet rape victimization is highest in 16- through 19-year-olds.² Pregnant patients also were excluded; yet the rate of physical abuse, 37% across class, race, and educational lines, is higher during pregnancy.³ Marital rape and acquaintance rape also were not included in the definition of acute domestic violence. These acts include sex resulting in whole or part from coercion, verbal or physical threats, undesired noncompliance with contraception, or force, and also include both physically nonviolent and physically violent sex. Approximately one in four US women report at least one life experience of rape (most often by a perpetrator known to the victim), and almost one in three women report an experience of attempted rape.³ Spousal rape occurs with greater frequency than rape of nonspouses, and spousal rape almost always occurs on more than one occasion.⁴ While spousal rape is most frequent in relationships in which other violent behaviors are ongoing, it has been reported in relationships in which no other forms of physical abuse occur, and it usually causes greater harm than rape by an unknown assailant.^{4,5} Regrettably, many US states and other industrialized and nonindustrialized countries do not recognize certain forms of marital rape as crimes.⁴

The authors also may have underestimated the cumulative lifetime prevalence of domestic violence exposure because they did not ask about marital or acquaintance rape, but only asked about threats and physical abuse from a former husband or boyfriend and they did not inquire about childhood sexual abuse, which is reported to have affected as many as one in five to one in three US women.⁴ Childhood sexual abuse may cause numerous adverse physical, emotional, and social sequelae and correlates strongly with wife rape and other types of adult domestic violence exposure.²

Regardless of the definition of domestic violence used, all surveys are likely to underestimate abuse.⁴ Women frequently are reluctant to disclose abuse because of feelings of self-blame, shame, loyalty to the abuser, or fear. Moreover, the ethnicity of subjects may affect survey results: women in many cultures are socialized to accept unwanted, forced sex or emotional chastisement as part of the husband's marital prerogative.⁴ For instance, Mexican-American and African-American community attitudes toward rape are significantly less feminist than those of whites, that is, more fault finding of victims and less willingness to define situations as rape.⁶ Furthermore, Mexican-American and African-American rape victims suffer greater psychological distress than white rape victims.⁶

Because of overly rigorous exclusion criteria and failure to inquire about certain types of abuse and because nonwhite victims are less likely to identify rape as rape, the data of Abbott et al may underestimate the magnitude of the domestic violence problem.

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1. Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women: incidence and prevalence in an emergency department population. *JAMA*. 1996;273:1763-1767.

2. Council on Scientific Affairs, American Medical Association. Violence against women: relevance for medical practitioners. *JAMA*. 1992;267:3184-3189.

3. Leidig MW. The continuum of violence against women: psychological and physical consequences. *J Am Coll Health*. 1992;40:149-155.

4. Heise LL, Raikes A, Watts CH, et al. Violence against women: a neglected public health issue in less developed countries. *Soc Sci Med*. 1994;39:1165-1179.

5. Coffey HP, Sefton S, Llabre M, et al. Cultural beliefs about rape and victims' response in three ethnic groups. *Am J Orthopsychiatry*. 1993;63:623-632.