

CJ: Okay, so that one's going and this one's going. Okay! Okay, so this is an oral history interview with Dr. Daniel Sheridan of Johns Hopkins University School of Nursing. We're going to talk to him today about the medical intervention into domestic violence treatment and prevention in the 1970's, the 80's and beyond. I'm Catherine Jacquet, a historian and postdoctoral fellow at Macalester College. The date is October 2nd, 2013 and we are at the Crown Plaza Riverfront in St. Paul, Minnesota. So Dr. Sheridan, thank you so much for your time today. Maybe we can start with the basics. Where were you born? Where are you from? When were you born and from there, we'll start -- we'll move into your path to medicine.

DS: All right, that'll work. I was born in Evergreen Park, Illinois which is a suburb of Chicago. And that was in 1954, November 29th. I was second of five children. I grew up in the city of Chicago. My late father was a Chicago police officer for 37 years. And when you work for the city of Chicago, you must live in the city of Chicago. I went to an all-guy's Catholic high school in Chicago which is pretty common to have; all went in all-guy Catholic schools. I started college at age 17. This was my first date, an early person to start college at 17. And at the -- when I started college, the Vietnam War was still going on. And they were still having a draft lottery. So at that point, they would have a lottery of dates that were pulled out and then they would pick whatever dates were picked for a second, third, fourth, fifth -- depending on their needs at that point. They would then draft people based on how lucky or unlucky one was and in having the -- your date of birth picked. So when I was in college, my date of birth, it was -- I forget exactly but it was pretty low. And it was good probability that I was going to get drafted into -- at that point, it was probably going to be the Army or the Marines. But they had an option at that point. That if you went to an Armed Forces recruiting station, you took an exam. You scored okay on the exam and they had a job again either at the Navy or the Air Force that would match your whatever scores and aptitude. You could do a four-year enlistment versus a two-year draft. So that's what I did. And I took this test and then they rattled off all these different jobs within the Air Force, most of which I had no idea what they were. And then they said, well, there's a position we could get you in for something called an operating room technician. And I said, Okay, what's that? And the recruiter said, do you watch MASH? Well at that point, MASH was not reruns. MASH was on TV. And the recruiter said, You know Hawkeye? Well yeah, Hawkeye is the surgeon. Well, when Hawkeye says scalpel, you'd be the person who gives him the scalpel when he says hemostat, you're the person who gives him the hemostat. So at that point, I figured, well, I think I'd rather be doing that than like shooting people. So I went ahead and signed up in the Air Force for four years. And was trained in San Antonio, Texas at Lackland Air Force Base. That's where all Air Force recruits are trained.

CJ: And up to that point, you had no medical training in college or anything?

DS: None, zero.

DS: Absolutely zero. No, no. I was actually working on a degree. I was -- in high school, I was on the school paper. I went to college with every intention of getting a degree in journalism and then I was sort of like had a little career detour for a while. And so I ended up being an OR tech. I was stationed. At that point, they were not sending a lot of new troops so much back to Vietnam. They're beginning to downsize. This is in the early '70's. This is probably 1972-73, somewhere in there.

CJ: So Nixon's Vietnamization was happening?

DS: It was beginning to wind down. It was beginning to wind down. So I think it was in '75 that Saigon fell and then we were totally -- well, for the most part, totally out of Vietnam. So I ended up being stationed at Wright-Patterson Air Force Base right outside of Dayton, Ohio or was it Dearborn, Ohio? And it was a very busy base for everyday surgeries that would happen on a large base of 30,000 plus active duty, their families. But they also would fly in wounded -- the wounded from Vietnam who had been sort of cleaned up a bit. Some had (inaudible) but needed a lot of follow-up surgeries, reconstructive surgeries. Sometimes, limbs that they were trying to save weren't savable so there were a fair amount of amputations. So at that point, I am now 19 and it was a pretty good education into the healthcare world and surgical world. I ended up spending about three-and-a-half years at Wright-Patterson. But along the way, I began to pick up more college credits. I had entered the Air Force with 16 college credits. And by the time I got out, I had 96.

CJ: Wow!

DS: When I've had about eight or nine months left in the service, I met Margie Joseph who eventually became my wife. I met her actually at a party at the editors of the college newspaper's house.

DS: Because even though I was in the military, at that point, I was working a pretty much permanent 3:00 to 11:30 at night shift. Which meant during the day, I could be a part-time college student. And I was continuing my degree towards journalism because my God, that's what I was doing when I was going to get drafted so I was being stubborn and I was going to finish it. So I met Marge and oh, we dated for several months. It was kind of interesting that she even talked to me because at that point, she was one of those folks who had just finished her master's degree at Cleveland State University and she would be part of the sit-in's at the ROTC Building to, you know, to protest against the Vietnam War and here she was, now dating somebody who was getting out of the military. So we dated for a while and then she actually moved from Cleveland to Dayton and then we kind of lived together. Back in those days, being recovering Catholics, we were living in sin back then.

CJ: Oh, that's right.

DS: Yes, oh yes. That was bad then. But we lived together for about a year-and-a-half and then as I finished up my final courses to get my Bachelor of Arts degree, it's in communication with a journalism major. And along that way, she and I also -- me initially and then Marge, actually worked for the Dayton Journal Herald. I started out as the night obituary writer. So when people of prominence would die, I would have to go into and write their obituaries. And that was your role. You start at the bottom. And then I became the night police reporter. And Marge, who now has a master's degree decided that she came in and got hired part-time to be the obituary writer. So we actually worked side by side for a while at the Dayton Journal Herald and this was when it was just becoming a computerized world in the world of journalism. And I actually kind of enjoyed it. I would drive around the city all evening, you know, and listening to police monitors and you would hear about oh, shootings and stabbings and many times, I would get to the scene first before the paramedics got there. And I found myself doing like emergency

first aid and I'd come back to the news desk and the editor would say, well, did you get the story? I'd go, well, kind of but the guy's going to (inaudible). And I found myself doing more of that medical.

CJ: And you're trained that way.

DS: I mean my training in the military, right. That was my evening job and you know, and so my training in the military and then I'm thinking, Okay, I'm like, you know, one course short of getting my Bachelor's in Journalism, and I said, You know what? I really think I want to become a nurse. My experience in the military showed me the nursing world and the physician world. And I really saw physicians who didn't have much of a personal life. They truly were and this is not a negative. They truly were like married to their job and especially for surgeons and trauma surgeons, you'd have to be. And also, the military introduced me to men who were nurses. I was so -- going to an all-guy's Catholic high school in a relatively tough neighborhood of Chicago with lots of friends who were sons of police officers and fire fighters. I had bought into 100% that myth that if a man chose to be a nurse; he absolutely had to be gay. And probably in those days, I used more inappropriate words than gay because hell, that's what you did. But it really opened up my eyes that these guys were A, anything but gay. Well, some were but most weren't. And they knew what they were doing and they were the ones training the doctors. And I said, Okay, I can do this. So we, in April of 1978, I graduated on one day and got married on the next. And then the next day, my wife and I put everything we owned into a very small U-Haul truck and we drove to Chicago because I needed to -- we went back to Chicago for a variety of reasons. I was considering a couple of different schools to go to for my nursing degree. But having been from Chicago, that's where my family was and I was able -- we were able to store everything that we owned which wasn't a whole heck of a lot back then in my parents' basement. And then we drove out west for our honeymoon, finally getting to Oregon which fits into the story later. We loved, loved Oregon. And so we were married in '78 and when we came back, we got our first apartment in Chicago. My wife was looking for a rape victim advocate program to volunteer, to be a volunteer with. Because prior to me meeting her, and I met her probably end of '76, '77 somewhere in there and she was finishing up her master's. She was one of Cleveland's first rape victim advocates. And she again...

CJ: I need to talk to her.

DS: She was with the Cleveland Rape Crisis Center.

DS: And she was, you know, always on call. And this was when rape advocacy was a really relatively new idea and hospitals and the police were just beginning to accept them. I wouldn't use the word embrace but to accept them because those early women didn't give them much choice. They kept being the squeaky wheel to all of the men. So when we got to Chicago, the closest rape victim advocate program was way up on Chicago's north side. And we lived on the far south side in the city but on the south side. And it really was going to be a challenge for her if she were called out in the middle of the night to get to a north side hospital which the only ones are being served in the north side. Within a timely period. But then she read in the local community newspaper, she read that there was a meeting going to be held to start Chicago's first battered women's hotline. And while her focus when she was an advocate wasn't so much on domestic violence, her focus was on sexual assault, she knew that many of the sexual assault

victims with whom she worked with were sexually assaulted by husband, ex-husband, boyfriend, ex-boyfriend. So she went to this meeting and she ended up being one of the founding mothers of Chicago's first battered women's hotline. And this is when call forwarding was a brand-new function on phones. I mean, people take it for granted now but we hadn't used it, you know, the rotary dial. Call forwarding was like really new. And she would be on call and you know, one night, the phone rang and I heard the phone first because I was working as an OR tech still to pay my way through, to get the pre-req's done to get into nursing school. Journalism majors don't take a lot of science. I needed to take some science courses to get in to apply for nursing school. So you know, I would hear the phone first and I would pick it up and go, Hello, and some woman would say, Help, my husband's beating me, and I said, Marge, it's for you, and I'd give her the phone. And then I said one day, well, what if like you're in the bathroom or something what am I supposed to say to these ladies? She said well, go to the hotline training. And so my wife volunteered me to be a volunteer on Chicago's first battered women's hotline. That was my introduction to this whole concept of interpersonal violence. I mean, you know, my life just has never experienced family violence. I mean, my father while he was a police officer, never threatened my mother, okay? He used corporal punishment with his sons but never with his daughters. In fact, he would often say to us, to his sons that real men never, ever, ever hit a woman. Even if a woman hits first, real men walk away. So he never hit my mother. I mean, they have their annual fight at tax time over what can be deducted or what couldn't. So there'd be some yelling and screaming but never abusive, never condescending, and never physical. And he would always be angry. He'd slam the door, walk around the block, come back and my mother did the taxes fine every year. And so that was kind of the -- sort of the background and then about six months later, that hotline with folks like Marge writing grants, got enough money to open Chicago's second battered women's shelter. And within a few weeks, my wife was the executive director of the shelter.

CJ: And were you a volunteer in the hotline this whole time?

DS: Yes. Which meant now I was a volunteer at the shelter.

CJ: Oh.

DS: Because I was married to the boss, that made me a safe male. There weren't a lot of men who were welcomed into the early days of the domestic violence movement and understandably so. Understandably so. First of all, there weren't a lot of men who really wanted to be a part of anything that dealt with women's issues and women's movements and safety. (inaudible), that's you know, even non-abusive guys still would not. It really wasn't something that many of them knew as an option. Okay, and so my volunteer work at the shelter had nothing to do with healthcare. I was the guy that would bring donated furniture in, bring broken donated furniture out. I was the guy that would fix anything that would be breaking, unclog toilets. I mean, that was my volunteer work. It was more manual labor.

CJ: A handyman.

DS: The handyman situation. But being in that shelter actually showed me quite visually and quite dramatically that the women and children that were coming into that shelter had significant injuries. They would have all sorts of bruises to their face. You could just see as they were just trying to walk up

and down the stairs how painful it was because of the bruises in areas at that point you couldn't see. And by this time, I had completed enough of my pre-req's that I was accepted into Rush College School of Nursing. Rush University or Rush College School of Nursing and I started out as a junior nursing student because I had two years. I actually had a previous degree. So I started out as a junior and I had the ability throughout all of my undergraduate nursing period of time and even in my master's degree that every time we'd have to do a paper, a presentation, a project, I was always able to -- I sometimes jokingly say manipulate but convince. Convince the instructor that if there was any way to bend the objectives of the class so that I could do something on topics like child abuse, child neglect, domestic violence, sexual assault, elder abuse, that I would do that. I also in my junior year at Rush, started an all-volunteer group called the Rush Coalition Against Spouse Abuse. And I didn't want to call it spouse abuse. I really, really didn't want to call it spouse abuse because I wanted to call it something that addressed the real issue, something against violence against women. And I really pushed for that and I pushed for that. And actually it was -- and I forget her name now but it was an administrator, a woman administrator pretty high up the Rush Presbyterian St. Luke's Hospital chain who basically said, well, there are a few battered men so we can't just say whatever we're going to name this, name it to be. So we ended up, I compromised and we ended up calling it spouse abuse which, you know, in retrospect, it was okay because we ended up having a core group of about 20 to 25 people both within the medical delivery world but also within the academic world who were pretty regular participants in a lot of what we did was educational in nature. So a lot of it was just a lot of education. We had no budget so we had bake sales.

CJ: Okay and were you like educating in terms of like the health impacts of violence?

DS: Yes and even just having awareness. Just having posters and awareness and trying to get to the medical people, the academics just to look at spouse abuse as a medical problem. Not just a public health problem, but a medical problem, not a social work or police problem. Because in those days, and this was 1980, I think when that started. In 1980, it was still considered very much a social work-legal issue and not a medical issue. And if it was medical, it was psychiatric. It was more of you know, well, you know, she was depressed and that's why she was beaten. Or she was difficult to live with. It was almost blaming her instead of looking at her psychiatric symptoms as being a consequence of living in an abusive relationship. It was almost the reverse at that time. But that's also when psychiatric medicine was still quite patriarchal in its view of things in general.

CJ: And can you just explain a little bit, you said it was medical, not just a public health.

DS: Public health.

CJ: Can you kind of (inaudible) that out a little bit for me?

DS: Yes. Medical more in the sense that you have acute injuries. That you had acute injuries that needed to be addressed and safety concerns that needed immediate attention. Versus the public health perspective that was looking more at surveillance, statistical gathering, prevention -- primary prevention, not that that's bad. We need that. But we need both. So there was a beginning understanding that this could be a public health issue. But there still was very little, if anything, that

addressed it as an acute medical issue that needed to have the emergent services right then and there when someone presents with acute injuries. So that Rush Coalition actually ended up staying in existence for many years. It stayed in existence through probably into the 90's and I'm jumping around because there's so many things. When I left -- I left Rush in '89 and I was at that point running a hospital-based domestic family violence program. But (inaudible) -- but the person who took after me, that program just didn't have the financial support to sustain itself. And in the early 90's, the Rush Coalition Against Spouse Abuse and the Family Violence Program within the hospital kind of dissolved. And that's because the person who was running the program, a wonderful person, was actively trying to complete her PhD work and anybody who understands when you're in that final, I've got to get this doctorate work done, so many things had to be put to the side, that those systems just weren't sustainable. So anyway, going back. So '80, 1980, I graduated with my Bachelor's in '82. During my bachelor's degree in nursing, for grades, to get grades I actually wrote the emergency rooms first policy and procedure on domestic violence. They didn't have one.

CJ: At Rush?

DS: At Rush. At Rush but now it's called Rush Biomedical Center. I think then it was Rush Presbyterian St. Luke's Medical Center.

CJ: All right.

DS: The hospital with the longest name. But I wrote their first policy procedure for a grade. I created wallet-sized domestic violence cards that could be put into women's bathrooms that had the handful of programs that had existed in Chicago in the suburbs that had either hotlines or shelters. And again, created that card for a grade and then printed the cards using funds from our bake sales. And then, you know, widely distributed them. Also during this time when I was a student, in the city of Chicago itself, an organization formed which I think is still in existence, called the Chicago Metropolitan Battered Women's Network.

CJ: Yeah, I'm pretty sure they're still in existence, yeah.

DS: And my wife, being the shelter director and the shelter's name was Rainbow House/Arco Iris, A-R-C-O I-R-I-S. And it was in the Pilsen/Little Village area and she was a member of that group. And they were struggling to find a location especially an accessible location that -- where they could hold their -- I think their monthly meetings. And so I was able through the Rush Coalition Against Spouse Abuse, to be able to have Rush as where the meeting were hosted because we were a totally accessible facility for people who had any mobility concerns. And so, we began hosting the meetings there. And again, I don't -- and they were hosted there for years after I left. I don't think that that continued as well. Which was very helpful because that was able to bring in a lot of the -- it showed to the hospital that this really was an issue that was much of everything, just Dan and his passion. That this truly was a citywide issue and to be involved in it was something pretty important.

CJ: Can I ask you a question on Dan and his passion?

DS: Okay.

CJ: So it is quite, from what I've read and from what you told me, it's very unusual, right, that people within the health world were addressing this issue. So can you talk a little bit about like the reaction to you and your colleagues in the work that you were doing from like a larger medical field at that time and how you maybe saw the change over time? The faculty at Rush, for the most part, were pretty okay with me doing this. I chose, when I was working on my master's degree at Rush, they didn't have anything close to what we now call forensic nursing. But that term forensic wasn't even being used at all.

CJ: That's the 90's, right?

DS: That came in the 90's. And I knew I wanted to get a master's degree but -- and at that point, within less than a year of graduating with my bachelor's degree, I actually was brought down to the emergency room to be an ER nurse, and I'll explain why in a minute. But when I chose to be -- to go after my master's, I chose to do a master's degree in psych/mental health. And not that I wanted to be a psych nurse in a traditional inpatient psychiatric unit. But I chose to get the training as a psych/mental health nurse because I also was seeing that not only were you having the physical traumas but you also were having significant emotional traumas. And PTSD symptoms. Now at that point in history, because of a lot of interest in PTSD with returning Vietnam veterans and this is when PTSD really began to be accepted and legitimized as a very real, a very real sequence of experiencing especially repeated traumatization, that I began to see in my work especially working in the ER now, these patients who had been beaten and I'm their staff nurse that they were having a lot of psychiatric sequences of that. And ER nurses generally, ER and trauma nurses, we're very good at what we do. But we're not very -- I use the term warm and fuzzy. We really have a lot of ER nurses like who prefer not even to talk to people. They just want to fix things. They just want to put that IV in and stop that bleeding and pump on that chest and get them in and get them out. And so, I knew I totally lacked the training and skills to be an active listener. To plant some nice seeds of some therapeutic value, to understand the overlap between mental health and domestic violence. So I chose to do that master's degree to give me skills that I didn't have. And that I wouldn't have had, had I chosen a more trauma-related master's path. And then right towards the end of completing my master's, my adviser, an extremely well-respected faculty person who I will not name, she said to me, You know, Dan, whenever you're done with this violence thing, whenever you're done with this abuse thing, you could make one heck of a good psych nurse. Which that message loud and clear to me said, She doesn't get it. She does not get it. And that was a relatively common view at that point in time. That this abuse thing, this violence thing, this was sort of a fad. This was sort of phase and it's really not that big of a deal. And you know, it's sort of, you know, if you were a psych patient who was in a domestically violent relationship, or sort of this little aside. It really wasn't the main issue. The main issue at least back then because this was a biochemical imbalance. And we'll just medicate you. You'll be fine. Okay? What is -- we're off the meds. But we'll just medicate you because it's a biochemical imbalance. And so she didn't get it but not just her but that was pretty much it was a lot of folks. You know, in the ER, the prevailing attitude is, And so, today, 2013, we have a lot of it (inaudible). But it's probably less than it was back then. About a week after I finished my bachelor's degree, I knocked on the door, set an appointment. I knocked on the door of the director of medical/surgical nursing at Rush, Dr. Marilee Donovan. And I walked Here I am, a new grad. The ink's

probably not even on my diploma and I walked and I said, "I want you to hire me to open up an ER-based, family violence intervention program." And she literally laughed. She broke out laughing. And she said, Come and see me when you have your master's degree. Have a nice day. And then she went back to her work. I was -- needless to say, flushed, red, angry, stormed out of that room and to spite her, I took the GRE's and I did okay on them and then that's what motivated me to get my master's degree. It was anger. About a month after I finished my master's degree, I went back to that same office. I knocked on Dr. Marilee Donovan's door. But this time, I had a white paper that I had written with as much research as I could find at that point, with a tentative budget and a possible funding stream of where we can get monies to help offset the cost of that. And so, she hired me.

CJ: And what year was that?

DS: 1986. So I graduated my master's in '85 but it wasn't until July 1st of '86 that I was able to open what ultimately I found out was the country's second hospital-based family violence intervention program. The first one I found out a few months later was created by Susan Hadley right here in the Minneapolis-St. Paul area. I believe in Hennepin County.

CJ: Were they also one of the first same programs that (inaudible)?

DS: It's one of the safe programs, yes. And so Susan had created a program here which I didn't know about until months later. And so I was able to create this program that started out initially with me being a half-time employee and then with grants, I became a fulltime employee within a few months because I wrote some grants. I purposely designed the program to have it half-owned by nursing and half-owned by social work. For a variety of reasons, also during the period when I completed my master's degree in nursing, my wife, Marge, completed her second master's degree. This time in social work at the Jane Addams School of Nursing. And I saw and working with her, working with the battered women's network that having something siloed just within one profession versus the other, was not going to be a good way to do things. So that I purposely had it half-owned by nursing and social worker which forced to some degree, nursing and social work to better communicate with each other. Because we don't always -- we weren't always doing that very well. The program did well. We initially -- it was me. I was the program. And we would -- and I'd be on call 24/7. So that's the person that would get called in. Or he will get, yeah. If your phone call would come at the middle of the night we're never again to call. And during the day, I had an awfully small office which used to be a storage closet which I cleaned out and made into an office. And you know, they would say, Dan, we got one for you. Within about a month or two of starting that program, there was at Rush, an unfunded fledgling group of volunteers. Rush had its own rape victim advocate program and it wasn't owned by any department. Nobody would do anything and so I was able to work that into the family violence program and then found enough funding to support that there be continuous training so we've had an adequate number of rape victims who would be available to be able to come in. Now, during that period of time, from '82, '83, '84, '85, '86, every hospital pretty much would do its own -- sexual assault exams. And this is when the term they would use back then, the rape kits. The rape kits were still relatively new phenomena. And actually in Chicago, they used the term the two oh. There was a police office in Chicago, I think he started out as Detective (inaudible) then he became sergeant then he became lieutenant but he created



this trademark and actually did pretty well with it financially. But it was when we were beginning to do standardized evidence collection.

CJ: Okay, for sexual assault.

DS: For sexual assault.

CJ: Not domestic violence so much.

DS: No, for sexual assault. And so, I would also start getting called in and I would talk the physicians step by step through the exam. And not just me but many of the ER nurses got very skilled at talking to physicians through the exam. Because especially at a teaching hospital, I mean, every month you've got a new intern.

CJ: All right.

DS: And these cases were relegated usually to the interns. Not to the attending. It was a training opportunity for the intern which meant if and when these cases ever went to criminal trial which could be years down the road, that intern probably has completed his or her residency and has moved on and they were almost impossible to track down to come back to testify. Which was almost a guarantee that few of these would go to trial even the ones that had evidence. But that's when standardization began to occur. I -- at the average, there'd be at least 30 to 40 cases a month. That would come in. Back then, they were either child abuse, domestic violence, elder abuse, and/or sexual assault that would come in.

CJ: Just to Rush?

DS: Just to Rush. Just to Rush. In some months, it would be more; some would be less. That's when I began to better document what was being said, to photograph injuries. This is when I first began to photograph and make that as part of the medical record which required a lot of meetings with how would you do that, so these photos are accessible but not easily accessible to people who shouldn't be looking at them. And it was 35 millimeter back then. I chose for then not to use the Polaroid so much but it was 35 millimeter. I also was doing a lot of training, a lot of education. In '86, when the program started, I saw that there was going to be a conference and it was going to be a conference in Massachusetts on nursing and domestic violence and sexual assault. And I submitted a paper and it got turned down. That was the year that the nursing network and violence against women started. And Christine King was one of the founding mothers of that and Jackie Campbell went to it. Later that year in '86, I actually met Jackie for the first time... In Springfield, Illinois. And I met her and immediately, we kind of connected. I did present at an Illinois Coalition Against Domestic Violence conference. I presented the fact that we had this hospital-based program and Jackie and I, we kind of connected and you know, I've heard her presentation. She heard mine and she was beginning to talk a lot about the domestic violence homicide work that she was beginning, was doing back then. So that and in '87, one of the Nursing Network on Violence Against Women had their next conference and I submitted a paper. I think the good Dr. Campbell put in a good word for me.

CJ: That's nice of her.

DS: And I was kind of welcomed in. I don't know if my abstract was poorly written or if it was my gender. I'm not sure. Not sure and never asked.

CJ: Because were there many men?

DS: None. Zero.

CJ: Okay, wow. Okay.

DS: No. There were none. And there were none for many years afterwards. But I did become involved in the Nursing Network on Violence Against Women and began to attend. And they don't really have annual conferences. It was more like every 18 months. Never really had much of a budget. It was an interesting association and it still is because it is an association of nurses who pretty much conduct the business more via a consensus model. More of a feminist-based consensus model.

CJ: Yeah, it sounds very...

DS: Versus the more traditional Robert rules structural model that a lot of professional associations by which they operate. And to this day, it's still somewhat loose in that way that there has to be sort of this consensus which doesn't always mean 100% agreement. It's sort of a consensus model. And stayed very involved with that group and still I'm a member. But in 1989, by now, my wife and I, we have two children. Born at Rush. And our oldest was in kindergarten getting ready to start first grade and our youngest was in diapers. And we lived in a neighborhood of Chicago that was kind of okay for us but it was beginning to become a little bit more of a dangerous neighborhood. And there was a little bit more of a gang influence going on and we didn't want -- we didn't want our kids to like going to the local schools and I said, Okay, so what are we going to do? Are we going -- do we have to move? So are we going to become a Chicago suburbanite and do the commute? Or we had always said after we came back from our honeymoon and loved Oregon, one of these days, we're going to move to Oregon. We had no idea how to pronounce this state.

CJ: Yeah, Oregon.

DS: It's sort of like saying Illinois, okay?

CJ: Right, right.

DS: You know, people from Oregon, when they hear Oregon, you know, but one of these days, we're going to move to Oregon. And so we took a trip and visited and fell in love with it again and so we said, Let's just do it. So we made a decision that we're moving to Oregon. Well by now, the family violence program I was running, I had enough grant money that I actually had two employees.

CJ: Wow, that's great.

DS: One more with a nursing background, one more of a social work background. And once this decision was made, the person who was going to take over the program from me had grown up in Portland, Oregon. So every time I'd be on the phone, I'd say, I'm going to move to Oregon. This little voice would

go, Oregon. Oregon. Oregon. So that time, I got to Oregon, I knew how to pronounce it pretty well. So in 1989, we moved to Oregon. Didn't know anybody. Had no jobs. We sold our house. I had bought a house. We had bought a house a few years earlier because one of the benefits of being a veteran is you can buy a house no money down. The GI Home Loan Bill.

CJ: Fantastic.

DS: And so we sold our house. We moved to Oregon. We're living in a hotel and we had a real estate agent that we had connected with. We found a beautiful home that had a view of Mt. Hood. It was one of those clear days which is not too often but beautiful and so we wanted this home and we got a hold of the mortgage company and they said, Okay, you got great credit and you got degrees out, the yin-yang. Okay. My wife had two masters'. I've got a masters. But you don't have a job. I said, Well, I'm a nurse. I can get a job. So they said, Okay, you have until this afternoon. So I went down to Oregon Health Sciences University to their hospital and I went to the nurse recruitment office and I said, I need a job. And they looked at my resume and they said, well, you could do a lot of different things but we don't have openings there but we do have a weekender trauma unit position available. So I came back with a piece of paper to the mortgage company. I had a job where I worked every Saturday and Sunday; 16 hours on Saturday, 16 hours on Sunday. Every weekend.

CJ: Were you planning -- when you moved -- when you all decided to move to Oregon, were you decided that you were going to continue in your work?

DS: No. I had told everybody clearly. Well no, I mean, in my work in the violence field?

CJ: Yeah, right.

DS: Yes.

CJ: Okay, okay.

DS: Yes, I actually had said, you know, I said that my goal would be to open up another violence program. My goal was to open another program but I needed a job. So and my wife was, having leaving the role of executive director, she came out looking to see what sort of jobs were out there in the domestic violence field. So I ended up doing the weekend job and I ended up doing that for about a year-and-a-half. My wife, there were no really shelter openings but there was an opening for an executive director of an all-volunteer community-based healthcare agency. And she had seen as a shelter director, that yes, you can provide safe housing for this very brief window of time. But there's a lot of other needs, longer-term needs, longer-term housing needs. You needed healthcare. You needed healthcare issues for her and the children. One of the things that would suck battered women back into the relationship was the need to be on his health plans and the children's health. And so, she really kind of moved to the not-for-profit healthcare world but then became on the board, she was a board -- and a board member of Bradley Angle House which is one of Portland's largest shelters. I was continuing to stay involved in the Nursing Network on Violence Against Women. I was continuously getting encouraged by Dr. Campbell that I needed to go on and get another degree, that the master's was not

good enough. And I resisted. I resisted that because at this point, I now had two bachelor's degrees and a master's degree. So about a year, a year-and-a-half after living in Oregon, Dr. Marilee Donovan, remember her? We talked about her a few minutes ago.

CJ: I remember her.

DS: That she's the one who -- to spite her, I went and got my master's? Well, one thing that was an outgrowth of my days at Rush is that when she approved the family violence program, she was my supervisor. And she was my mentor. And we developed a very good professional working relationship that continued. Well, about a year-and-a-half into Oregon, she was offered and took the position as vice president of nursing at Oregon Health Sciences University Hospital. So needless to say, within just a few weeks of her arriving to Oregon Health Sciences University, she found in the budget some monies for me to open up another family violence intervention center. I think we called that one the domestic violence intervention program.

CJ: By that point, the language had changed.

DS: Had changed a bit.

CJ: Spouse abuse or wife abuse to.

DS: And so, this is probably around 1990. Something around there. Around 1990-ish. So I'm now running another program and it was right around that time -- and I had done some publishing, I had a few -- my early works had gone out. Some of it, with some of the mentorship from Dr. Campbell, from Jackie. And I was beginning to do some training around Oregon and other places, some lectures and presentations, and I saw a advertisement for a day-long training put on by this nurse called Virginia Lynch. And it was probably about 1991. I went to at training in Portland by Virginia Lynch. And back then -- well, Virginia Lynch was talking about this concept called forensic nursing. And it just -- and attending her day-long training, it really put a name to what I was doing, because I didn't really know what to call myself, even though I had been a member of the Emergency Nurses Association, you know, ER -- it really was not emergency room nursing per se, but she put a name to it and it really made a whole bunch of sense. And that began sort of a communication relationship with Virginia, and Virginia had actually been a -- was at that point a death investigator, a nurse -- one of the first nurses in the country to do death scene investigation in Valdosta, Georgia. But she did this training and she talked about child abuse and sexual assault and domestic violence and the role of nurses in evidence collection and documentation and photos. And in the packet of articles that we totally ignored in those days, copyright, you just made copies of everything, it was actually an article which I had written, you know. So it's like, wow. This is -- and we began sort of -- this sort of collegial friendship. And in 1992, she asked me to come to Minnesota, where they were having the inaugural meeting of nurses around the country who were doing sexual assault -- mostly sexual assault, some domestic violence work. At that point, my work was more domestic family violence, not sexual assault per se. And I was asked to come here, but at that point also, in '92, Dr. Campbell's continuous pressure for me to get my doctorate wore off and I had just started my Ph.D. And I didn't have money to drive around the block, much less come on my own dime to Minnesota to come to a meeting. And so, I was not able to come. But in 1992, here in Minnesota, the

International Association of Forensic Nurses was born. And I didn't really join until '93...when they had -- their next conference was in California. And I joined in '93 and my member number was 251.

CJ: And were you also one of few men still at that point?

DS: Only.

CJ: Again.

DS: Only. Yeah. Still only. Within the -- by that point, within the nursing network and violence against women, we actually, in the early '90s, had a couple. There were a couple of men...who were involved. Never within that association was my gender, I believe, an issue. But, you know, once I was into the nursing network, I don't know about that first year. It could have just been a poorly written abstract. Who knows.

CJ: Yeah.

DS: But once there, and once meeting, interacting, the gender was a non-issue. Within the forensic nursing world, my gender was a non-issue. It really was not. And what I actually learned as a nurse, nursing student, and especially in my first year doing medical surgical nursing, before going to the ER, then as an ER nurse, that when you're a man who's a nurse -- and by the way, I'm going to say for the record, I hate the term male nurse. I hate it. Because we don't say -- well, we don't say female pilot. We say she's the pilot. She's the first officer.

CJ: Yeah. Because it assumes that the normative nurse is woman...

DS: That's right.

CJ: ...and you add male to -- and you guys would be (inaudible).

DS: And we don't say female physician. Okay?

CJ: We might have in the early.

DS: We probably did.

CJ: But not anymore.

DS: But not anymore. But now, we still talk about, oh, you're a male nurse. No. I'm a nurse that's male. Okay? And so, it wasn't an issue with those associations. And what I learned just as a nurse, being male, was that when I had to do a care of women -- patients who were women that dealt with what -- we use the term peri-care. Putting Foley catheters in; somebody's incontinent and you have to clean them down in the vaginal...rectal areas. -- or, you know, somebody needs a dressing changed and maybe they had a breast biopsy...or they've had a mastectomy and they have to have a dressing changed, that the ability to come in and be a professional, even though I'm male, having to do care of a woman, especially that's going to expose body parts...you learn pretty quickly how to do that in a way that is respectful, that is professional, that also is sending the message that if you don't -- you know, if you don't want me

to do this, it's okay. Okay? I'll try to find somebody else. But never in my work doing more standard traditional nursing did I have a patient who was female...say, No. I don't want you to provide my care. Because for a lot of patients, especially in those days, elderly women patients, having a man come in and says he's the nurse, this was, like, news to them, too. Its like, well, how can you be a nurse? You're a man. Yes. I am. This was a whole paradigm shift...even for some of the patients to deal with. And how about in terms of, like, when you were doing your advocacy work with abused women, how did the women respond to you? Domestic violence, almost never a problem. When I began, even though I had talked hundreds and hundreds and hundreds of physicians through sexual assault exams, I really did not begin doing independent, my own sexual assault exams, until I was living in Baltimore. And even to this day, I'm still actually on staff at Mercy Medical Center in Baltimore. So if I'm going to be back in Baltimore, which I have lots of plans to be back there for windows of time, I'll pull some (inaudible) call. And if I come in to do an exam and when I walk into the room, I usually say, Hi. My name's Dr. Dan Sheridan. I'm a forensic nurse and I'm here today to do your exam. The non-verbal communication that I get is, Oh, shit. It's a man. That's the non-verbal. Okay? And I sit down, much as we're sitting right here. I'm at a comfortable distance...away. I try my best to be either on eye-to-eye contact or preferably have her sit slightly higher than me. And I'm a big guy, so sometimes I can slouch down a bit. And I'm trying to convey a message with my non-verbals that you are in control of this exam. I go through a relatively detailed oral summary of what it is that I'm going to do. I often will say, you know, "I'm highly trained to do this. I've been doing this for many, many years. And this is what your exam's going to consist of. Well, first of all, we'll go in. I'm going to ask you a lot of different questions. It's helpful if you are as truthful as you can. It's going to help me make sure I do a thorough head to toe exam; I don't miss things. But if there's stuff you don't want to tell me, you don't have to." I always have present during the physical exam -- I use the term a chaperone. And I even -- when -- I have now trained hundreds and hundreds of nurses to do sexual assault exams, and most of them women. And I even encourage the women, "You shouldn't be doing these very sensitive, and at times invasive, exams without having somebody else in the room." It's for everybody's protection. And they're, Oh, no. It's fine. It's a woman and a woman. Well, not necessarily. And I always wanted -- and I would use -- always use the advocate on call...as my chaperone. Only if, A, the patient agrees to it. And B, if the advocate agrees. Okay? Because they may -- sometimes, advocates are on call for several hospitals...and they may not be able to be there the entire exam. And I'm a firm believer in that because, having married someone who was a rape victim advocate, who, very strongly and still to this day, believes advocates need to be there during the entire process...because how can they advocate if they're not in the room?

CJ: They're not there. Right.

DS: They can't advocate from afar. And so, I would always have that person there. So I would explain it all. And truly, within a few minutes of just the history taking...my gender became a non-issue.

CJ: Because you build that rapport.

DS: I built a rapport. And I say, Yes. I'm going to have to touch you and I literally am going to touch you from head to toe. But I will tell you before I touch you.

CJ: Before you do that. Right.

DS: At any point, you want me to stop? Say stop. And I stop. "If you want me to do a part of it and then you don't want, just tell me to stop and I stop." And I actually say several times, "you are in control of this exam." I'm going to tell you what I'm going to do, but it's totally up to you. I've never had, knock on wood, could happen, I've never had a woman say, No. I don't want you to do the exam. I've never had a woman say, Stop at any point...during the exam. There have been a few times, because it's been so uncomfortable, that I've stopped an exam because something was too painful. Especially if I was doing a speculum exam. There is times that I stopped. Because evidence is secondary to health and...medical -- that's all, you know, that's all secondary. So it really was -- it's not really an issue. When I train, and I base this on my real world clinical experiences, when I train, especially mixed audiences of nurses, men and women, I'll say, this is not a gendered issue. Especially in battered women. Battered women are literally dying to tell somebody what's happening. And your gender is not the issue. The issue is are you conveying that you really want to hear...what they have to say? If you're standing above somebody with your white lab coat or your scrubs on, stethoscope around your neck and your clipboard, "your husband doesn't beat you; does he?" You're not going to get...a positive assessment. Because you're not really conveying. Or...if she says, yeah. You know, yes. My husband hit me, and the first thing you say is, well, geeze. Why do you stay? That's victim blaming.

CJ: Which was pretty typical in the '70s, from what I've read; right? I mean, that was.

DS: Oh my God. Yes. It's typical today. So first of all, I have a flood of ideas. So just, you know, just keep on track. Feel free to interrupt and keep me back. Okay.

CJ: No worries whatsoever. Maybe we should get back to forensic nursing...

DS: Okay.

CJ: ...early 1990s and.

DS: All right. I came back from that training with Virginia and really began to say that what I was doing was forensic nursing. And -- because I became a convert. It really made so much sense to me. So I was running the program at Oregon Health Sciences University and, you know, that program started again in probably -- I'm going to say '90, '91. '92, I applied to and starting very part-time the Ph.D. program. And I -- and so, now I'm running the family violence -- domestic violence intervention program at University Hospital in Portland. Didn't see much of the child abuse. At that point, the pediatricians, we had that sort of, and the social workers had that sort of niche, and then they weren't sort of open to a nurse collaborating so much with them. But I also began to do a little bit more elder abuse work back then. I began to do a little bit of training and consulting just on injuries and wounds with the state of Oregon, protective services division, the division that also was doing abusive of institutionalized people with disabilities. But several years into running the program at university hospital, Dr. Donovan actually changed roles. She was then no longer the vice-president. She left the hospital. She was doing some other things in Portland, but she went back to doing more -- her specialty was basically pain management. And she was able to go into the Kaiser Permanente system to -- really to do some creative

things around having nurses involved and actively involved in chronic pain. And within just a few months of the new vice-president of nursing coming and taking over, I was no longer employed as a director of the domestic violence program. So I was sort of laid off from that role. And so, what do you do when you get laid off? I just threw all my energies into continuing my Ph.D. work. So I became a full-time Ph.D. student. And went back, part-time, to work in the operating room as an OR nurse...using all of my OR tech skills that I had learned in the military. Kind of dusted the -- I got the WD-40 out, got the rust off of that, and began to moonlight in the very, very busy operating rooms at University Hospital, which was a level one trauma center as well. So that's what I did to pay the mortgage, because at that point -- when we moved to Oregon, we didn't -- I didn't move there to go to school. We had moved there to raise a family...and bought a house and dependent on two incomes and. So I was working on my Ph.D. The Ph.D. took me -- they allowed seven years to do it. I took seven. I didn't want to be Dr. Dan and divorced and not having seen my kids grow up. So, you know, at this point in time, my kids were at the age where they were school-age kids involved in the trillion things that kids get involved in. And so, I did my Ph.D. and at a certain point in that process, Dr. Campbell actually became one of my committee members.

CJ: And was your work continued to be focused on violence against women (inaudible).

DS: Yes. Yes. The initial committee that I had picked had -- we're nurses, Ph.D.-level nurses on faculty, who had done some really wonderful work in the mental health psychiatric aspects of domestic violence. And so, I was sort of told that you really have to have them on your committee. Okay? Because they're the people who do it and they were really trying to steer me, mentor me, push me, with me dragging my feet the whole time to do a mental health focused dissertation, looking at the psychiatrics (inaudible). Well, at this point, I had bought into this whole forensic acute trauma world and it was kind of an oil and water situation. And in retrospect, now having mentored a number of my own Ph.D. students, I probably was not as kind to them as I could have been as they were attempting to mentor me in the world that they knew. But I was in a different world. So at one point, I was kind of stalled in my progress through my Ph.D. program and I went to Dr. Carol Lindeman, who was then dean of the school at OHSU, working on science university. And I said, You know, I really am stalled. And she says, Yes. I know that. Okay? And I think I have got to change my committee, but I'm afraid if fire my committee -- I was told I'm going to burn these bridges and you will never, you know, and these -- all these bridges will be burned and I'll have ruined this professional relationship. And being Lindeman, in the infinite wisdom that deans have, said, Funny thing about bridges. If you burn a bridge, you can always, like, either drag down the road and find another one, or, she says -- she went, Bridges have been known to be rebuilt. You need to do what you need to do...to finish your Ph.D. And so, I brought on a new committee, and it included Jack Tample [phonetic]...as an external member. And the topic I chose was based on a meeting that had taken place with not only Dr. Campbell, but also several of the key members of the nursing network and violence against women international. As that group of nurses sort of matured in their professional academic development, there was a splinter group created called the Nursing Research Consortium...on Violence and Abuse. I was the token clinician. Because my world was the clinical world. My world was taking a lot of the great research that was being done in those early days and say, okay. How does that translate to what do you do at 3:00 in the morning when you have



that victimized patient in front of you? And so, I came in and helped in the development and strategizing of a number of grants that then began looking at battery during pregnancy, began looking at more of the homicide-related work. And I always kind of brought in, and my role was, and I was fine with this role, was to bring in sort of the clinical component.

CJ: And is work you were in before the Ph.D.

DS: This -- and during. This mostly. This is pretty much during. You know? And I was almost the perpetual student for a while. Okay? So a lot of this was during my work as the student. And so, there was one meeting that we had, as the Nursing Research Consortium, that we were -- they were talking about, you know, what do we need to be looking at? What tools need to be developed? And we began talking about a concept called harassment and what was the role -- I mean, certainly we knew about physical abuse. We knew about psychological abuse. But we also knew from both the research and the clinical world that leaving an abusive relationship was definitely the most deadly time. That if a woman is going to be killed in domestic violence, more than likely, it's going to occur in that process of leaving. When finally in his brain, that light bulb goes off that this time she's not coming back, and if I can't have her, no one else will. So we began to talk about this process of leaving and we began talking about, and I began talking to others about harassment. And so, you know, what were some of the strategies and tactics that men would use to suck women back into that relationship? And the whole concept of harassment came up. And so, we all sort of decided, I think it was over a bottle of red something, we decided that Dan's dissertation topic needs to be looking at creating something, a brain, that light bulb goes off that this time she's not coming back, and if I can't have her, no one else will. So we began to talk about this process of leaving and we began talking about, and I began talking to others about harassment. And so, you know, what were some of the strategies and tactics that men would use to suck women back into that relationship? And the whole concept of harassment came up. And so, we all sort of decided, I think it was over a bottle of red something, we decided that Dan's dissertation topic needs to be looking at creating something, a tool, to measure harassment.

CJ: Oh, this is your harass scale; right?

DS: So. So I now have an idea. And so, what I ended up doing is I came back and, sure enough, the -- my newly formed committee thought this was a brilliant idea. And I ended up doing, in retrospect, what's called a triangulated psychometric dissertation. Meaning, so do I just sit down and just me create a tool? So I had to go into this whole science of instrument development. And ideally, instrument development that was based on the voices of women. So part of my dissertation was, and this was when IRBs were a little bit looser than they are now, is that for course work that I had to take in qualitative research, I, for my course, was able to audio record a pretty large number of women in the process, women. And I said to -- and when you look at the process of living, if somebody is actually in a shelter, that's kind of the process potentially of leaving. They left and they're in shelter. Because we wanted to look at what's the process of leaving and inherent risk there. I also interviewed a number of battered women community-based service providers and advocates; many of them survivors. Not all, but many of them were survivors. And said, okay. When I say the word harassment in the context of leaving an abusive relationship, what does that mean to you? Audio record them. Audio recording. I transcribed one

myself, never having taken typing...and realized, okay. I'm going to figure out a way to pay for it. And pay someone to transcribe the rest. And then, using -- Norman Denzin has a process, a system in qualitative research, that's relatively simple. It's not as complex as grounded theory or phonology. But I use something called interpretive interactionism, which is a branch of symbolic interactionism to basically just set up clusters and codes. And I was able to come up with a 45-item tool. My original tool was 45 items. And was able -- again, in a measurement course -- again, this is -- you could do these things, to get about 30 women to -- who were abused, to kind of, like, take that and...to comment on it. And so, I - from that input and this sub-group, I was able to narrow the 45 items down to 23. Well, now I'm approaching the fact that I'm approaching the fact that if I need to go out and now submit to IRB, find a population to test this on, I'm going to be on the seven year limit that one could have to finish their Ph.D. And this is where the beauty of having a consortium and a network of colleagues. So the good Dr. Campbell, and then Christine King and Joe Ryan, members of the Nursing Research Consortium, had ongoing research projects already approved by the IRB and they were able to go back to their IRBs to include, and they were using instruments within their populations, and they were able to include the harass tool as one of the tools that they were going to collect data on. And I was able to convince the Ph.D. folks that OHSU that I could do a secondary data analysis of my own tool. And as I said, the only reason they approved it, because it was my own tool. It was the secondary data analysis of somebody else. Okay? So I was able to get a pretty large sample of completed harass tools from one of Dr. Campbell's studies, and then both of them were used in the danger assessment. And Dr. Campbell was just phenomenal in her work around lethality -- domestic violence lethality predictors and risk factors. And I was able to use the harass tool and do a lot of correlations between lethality off the danger assessment with the harass, but also there were measurements of psychological abuse that were being collected. I was able to compare them and was really able to show that harassment, in the process of leaving, is a unique process and that within the scale I developed within the populations that were tested, there were three subscales. one of the subscales was actually looking at stalking and if and how it factored out.

CJ: As a form of harassment?

DS: As a form of harassment. And that the stalking items, and the stalking items might be shows up wherever I am, ignores court orders to stay away from me. ? That the stalking items much more highly correlated to the risk of homicide items coming up the danger assessment. So that it really helped guide us in the fact that leaving an abusive relationship we know is dangerous. Without a safety plan. So we're not saying women...stay because it's dangerous. It's dangerous to stay, it's dangerous to leave. But if you don't have a safety plan, it could be more dangerous. So it led us to really look at the fact that when women leave, the guys that then stalk her are even more dangerous...than the guys who don't. And there's now been a lot of additional stalking work that's been done by other folks around there. And the harass tool is still used clinically. I don't know. It's been used in several other studies, but I haven't really -- I kind of reentered a little bit more of the clinical world. And so, that was my dissertation and I was encouraged by Dr. Campbell to do a post-doc. Didn't. Still haven't. I, by now, as I was finishing up my Ph.D. I really was sort of recruited into being a consultant for the state of Oregon...Within their disabilities abuse investigation systems. In Oregon, in the mid-90s, and it still goes on now in many

states, the federal government, Department of Justice, was going around to states. States historically used to have these large institutions or schools, and I put that in quotes, where people with profound physical cognitive disabilities, often very deformed bodies, cognitively impaired, some of them high functioning, most of them now. Were kind of hidden from the general public and sent off usually to rural areas...to live in these institutions.

CJ: Yeah. Kind of like school/asylum.

DS: Yeah. Maybe -- yes. And again -- and the asylum was probably a word that was more appropriate for some of the mental health facilities. This is -- these were different than the mental. That was almost a related but separate...system...of schools, of sectors. And so -- but these were folks who really had physical and cognitive disabilities, that we really weren't talking about people who looked fine but had a secret mental illness. These people often just -- they're physically...often deformed and...and have special physical...needs. And the Department of Justice, through advocacy in the disabilities world was going around basically forcing states to shut down these large institutions and place folks into community-based homes. To try to, as best as possible, integrate the people with disabilities into the community. And because there was a lot of abuses going on. And the state began to use me during this period time to come in and do training with their staff on forensic wound identification, documentation; things that I was continuing to build and do. And then, so when I graduated in '98 with my Ph.D., I was offered a half-time position, full benefits, to work for the state of Oregon as an abuse investigator. So I was a nurse who carried a badge. So I didn't go into academia. I would go out with the state police, local police. I would go out with civilian investigators into large and small facilities with people with disabilities, and I also began to do some work with adult protective services. Which at that point were two separate entities. Okay?

CJ: So this is a huge -- I'm just thinking about, like, your work in the '80s, when it was just, like, your passion. Nobody was, you know, really believing it to be (inaudible) to now, the late '90s, where you're being hired by the state. I mean, that's an incredible change.

DS: It was an exciting change. And I loved the fact that I could have this half-time with benefits, because at that point I had children as well, and my wife, because I was also starting to do more national-level trainings and I was on various sundry boards and, you know. At one point, I was on the board of directors of the nursing network against violence against women and I was getting more involved with some of the national committee work and really was starting to do a lot of training around this issue, especially around the forensic wounds. And that job, with the state, truly made me a believer that injuries do speak to you. In fact, many of the lectures I give have some variation of a title When Injuries Speak. And with training, you can look at an injury and you can listen to what the injury's telling you of how that injury occurred. Now, you listen to the history being given by the child, the battered woman, the sexual assault patient, the elderly person, the caregiver, the parent. Okay? And is there consistency or not between what you're being told and what the injury is telling you? And you begin to think that you have to learn things like mechanisms of injury, mechanically how would things occur. You know, what types of things cause abrasions, what things cause bruises. Cuts and lacerations are not the same; they're totally different. They both have skin that's open and bleeding, but how it got there is different.

And in the forensic world, you really have to have a lot of precision in your documentation. And I began to do a lot more trainings and the state allowed me to come and go. And I would say jokingly, in my trainings, that the only thing -- I'm a clinician. The only thing that would ever bring me back to academia would be if I had a chance to set up either a forensic master's program or graduate level forensic work. And lo and behold, be careful what you wish for.

CJ: Because that's what happened?

DS: Because the then dean of the school of nursing at Hopkins, who had heard about me through Jackie, actually heard me present and I got a phone call that said, "Well, how would you like to, like, come to Hopkins and set up forensic nursing course work there?" So. I would bake cupcakes. That was -- my fundraising was cupcakes. It was becoming increasingly so in the '90s. But there was -- there were a lot of discussions going on. And I have co-presented. I know of (inaudible). You know, they were, like, gosh. Their monograph, they wrote this monograph, was just, you know, it's all we had. They were phenomenal. But there was that time during the early '90s that there was this shift that domestic violence was becoming less of a women's advocacy based issue and it was becoming a career choice. It was becoming professionalized. And the concern was then -- and I think still now, in that process of legitimizing that domestic violence, subsequently called intimate partner violence, so they got a politically correct term, as this became a legitimized professional issue, would we lose the voices of the victims in that process? And I think that debate's still going on. That debate is going on. I know it goes on within forensic nursing. I have a lot of, how should we say, animated discussions with my forensic nursing colleagues, the leaders within forensic nursing, who say the advocate should never be in the room during the exam. I go, Why not? Well, because they potentially can be called in as a witness. Well, yes. So why wouldn't you have an advocate in the room? If you read the national protocol that has come out of the Department of Justice, the national protocol, and I forget the exact title, it basically says best practice is to have an advocate in the room. But there's a lot of nurses who not only don't do it, it's in their policy. And to me -- that, to me, is a concern because whatever care you're providing, whether it's to a battered woman, to a patient who has experienced sexual assault who's reporting it, or to, you know, elder -- that your care should be the same whether there's an advocate in the room or not. Now, if I'm the nurse and you are the patient and you don't want that person there, that's a whole different story. Absolutely that's a whole different story. Okay? That's a whole different story. But that, to me, is an ongoing concern, that we have made this such a career choice, that we have people who are choosing this as their career, and do they really have in their heart of hearts that passion? I've been called a zealot on occasion, probably accurate in those early days. Now, I say its passion. Are they really there with that -- I use the word patient, but victim-focused. You know, when I train nurses, I really make sure that I say, You are never to write the word victim in your notes because you didn't go to nursing school to learn how to do victim care. You went to nursing school to learn how to do patient care. And what gives you the right to touch someone from head to toe, what gives you the right to insert a speculum and do an assessment is that you're a nurse and that's your patient. Now, you can say victimized patient. That's fine. Or a patient who reports being victimized. But that's not a victim. That's your patient.

CJ: Because you're keeping -- the healthcare is the focus.

DS: That's right. And I also talk a lot, and I have been for years, around the choice of language in our notes, which is going to leave me to a little bit of an aside, and I know this audio, not visual. But have you noticed I have musical notes on my tie? I've got about 30 ties with musical notes. I have no musical talent. I can't music. I can't play an instrument. Zero talent. But my kids have known for years what to buy Dad for his birthday, Father's Day, and Christmas; find a stupid tie. And they're now 30 and 27. Find a stupid tie that has notes on it and he'll be happy. I wear ties with notes whenever I'm training or whenever I'm walking around at Hopkins with students who see me, and I wear ties with notes to remind me to remind them that they write notes. We call them nursing notes, progress notes, narrative notes, medical notes. Investigators write investigative notes. Social workers write notes. Everybody writes notes. And what you put or don't put in your notes has tremendous forensic implications. And we learn very quickly it's what you don't document that's more likely to come back and haunt you later versus what you do. And so, it's sort of a walking prop. It's one of those, you know, quirky professor things. That if I actually showed up some place without a note tie and people who know me see me, they would give me nothing but grief. Because it's just where's the notes. Okay? And so -- and the importance of the documentation and that really, you know, over the years, has become so critical. And so, we do have to have the professional documentation. We do have to make sure that it's unbiased. One of the things that I really hate seeing in medical records, and I've hated this for years, physicians and nurses constantly will write in the medical record alleged rape. Alleged rape. Alleged domestic violence. Alleged child abuse. And I say to professionals when I train them, would you ever dare write alleged chest pain? Would you ever write, 'Patient allegedly is pregnant' or patient alleges that she was up night with multiple episodes of diarrhea? See, the day you can write alleged chest pain, then you say alleged rape. Or alleged domestic violence. Alleged is a legal term. It's a term used by the media so they're not sued. It's not a medical. It's not an alleged raped. It's a reported or suspected rape. It's not alleged domestic violence. She or he is reporting it...or suspects.

CJ: Like you report chest pain.

DS: Yes. Yeah. People report chest pain. And the other thing that I really, really, really have issues around in the documentation, and passionate about, is -- in a bad way, passion, when medical professionals write, patient refused. Patient refused to make a police report. Patient refused to take their medication. Patient refused to meet with the social worker. Bad patient. You're on time out. I mean, that word refused is saying, what would a good patient do? Well, good patients take their medications. Good patients who have been beaten make a police report. That word refused is -- we use the term pejorative. It's a biased term. It's -- I'm fine if they were to say, Patient declined. I'll take it. It's a little loaded, but why not write, This patient said? Patient states? Patient states, 'I don't want to make a police report.' Patient said, 'I don't want to take my medication.' It's going to involve that judgment, and we are very judgmental in healthcare. Very. We're still -- healthcare is still very paternalistic. Very paternalistic. And, you know, we know what's best, versus empowering people to make choices. CJ: So you still see that as one of the major... involve that judgment, and we are very judgmental in healthcare. Very. We're still -- healthcare is still very paternalistic. Very paternalistic. And, you know, we know what's best, versus empowering people to make choices.

CJ: So you still see that as one of the major...

DS: Oh, it's.

CJ: ...problems? Because that was one of the major issues, right, in the '70s as well, when these issues were being raised within the health community. That continues to be a major issue. Because that was one of the major issues, right, in the '70s as well, when these issues were being raised within the health community. That continues to be a major issue.

DS: Patient claims she was rape. You know, when a medical provider wrote, Patient claims that somebody did something, the message loud and clear is we don't believe them. And maybe there are people who are untruthful.

DS: But.

CJ: That's not your job.

DS: That's not your job. You don't say, Patient claims they're having chest pain. Maybe they're not having chest pain, but you're going to work it up as if they are. Because lo and behold the day you don't, that's when they walk out the door and drop dead of a heart attack. So you do proceed with what they're telling you. You proceed with that. So I do a lot of training. And again, this is where I really try to keep that advocacy alive that was instilled in me as a newlywed by my wife, who, today, still today, keeps me humble in the fact that the voices of the patient, the voices of women, the voices of the disabled, the voices of the elderly, are not lost in the medicalization of abuse issues. And that was a discussion that went on again in the '70s as it became more than just, you know, Anne Craft there, that we began to give them a lot more physicians and a lot more nurses. We have to make sure we don't medicalize or professionalize this. We have to keep the voices there. And that's an ongoing struggle. That's going to continue.

CJ: Well, especially -- right. At the beginning, there was no medical response and you needed the medicalization, but then, what's, you know, at what cost; right? So trying to find that.

DS: Well, what medicalized it, what really helped to bring a lot of new people in, is because at a certain point, monies became available. Interesting that all of a sudden people who had no expertise in this area wrote some phenomenal grants...and they got money to do this work. Because they're good grant writers. Okay? Now, some of the folks ended up, and continue to be, phenomenal folks. Okay? But they were chasing the money and it's (inaudible) that there was monies that are there. Well, they're not so much there anymore. But they were. There was money for a while. And -- but I guess, we're beginning to look at that that is an ongoing issue, that I really do think that those of us who were involved in those early days where this truly was a movement, where this truly was advocacy, that we need to continue, especially as we train the next generation, that -- to not lose that commitment to making sure the voices of the patients and the victims we serve -- we got to make sure their voices are heard. And the needs today may or may not be the same as the needs of their mothers and grandmothers. I mean, I've been doing this for long enough now that it's basically, you know, that the grandkids, you know, potentially are the ones being abused right now. And so, you begin to look at that and then that issue, we need to really, I think, guard against. We can't lose that patient/victim-focused approach to what we do.