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FREE-FLOATING ANGER

Excerpts from Deadly Consequences
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I FIRST BECAME AWARE OF VIOLENCE AS A MAJOR THREAT to young people during my third year at Harvard Medical School.

The third year is the clinical year, the time when frightened students begin to practice medicine on living patients. For me and for many, the third year is a crash course in real life. Every hospital room we enter teaches new lessons about the bad things that can happen to people.

In late January of 1978, as part of my third-year training, I did a six week surgical rotation at Boston's Brigham and Women Hospital. I didn't like surgery. My husband and I were expecting our first child. In those early months of pregnancy, everything nauseated me, especially the sights and the smells of the operating room. During my six weeks at the Brigham, I probably dashed out of more rooms and vomited in more hallways than any other student in the school's history.

The surgical rotation included an extended stint in the emergency room. On a typical night the doors to the Brigham E.R. would swing open to admit every imaginable kind of case. There were people with abdominal pain and urinary tract infections. There were people pulled from car wrecks. People with sore throats, broken bones, infected toes. Kids who had swallowed their parents' pills. And teenagers—an endless parade of teens; cut, shot, bleeding, dead, the victims of would-be or actual homicides.

The pace in the emergency room was fast and the pressure was almost always on. During one twelve-hour shift, the surgical resident looking over my shoulder decided that I was ready; my lesson for the night would be suturing. For several weeks I had been practicing. Using a surgical needle and thread, I had closed great juicy gashes

slashed in navel oranges. I had practiced taking small, neat stitches on artificial skin. But nothing prepared me for the moment when I thrust a needle through the resistant skin of a squirming person.

That night I treated all the patients who arrived needing stitches. I explained to each that I was a student just learning to suture and that my work would be closely supervised by a resident. My stitching was slow, but competent. The resident praised my efforts and I was feeling pretty good.

At around 3 A.M., a young man not yet 20 years old arrived pressing a blood-stained shirt to a laceration over his eyebrow. I told him I was a student and that got us talking. As I cleaned and stitched his wound, the patient told me what had happened. He'd been to a party. He had had quite a lot to drink. A throw-away comment from a guy he barely knew ignited his anger. An argument erupted. Insults were shouted. A crowd of excited on-lookers gathered and began to egg the disputants on. A shove was given, and then a punch was thrown. A knife flashed across the young man's brow. An inch lower and he would have lost his eye.

I could see that the young man's anger had not cooled down one bit in the hour since the fight. As I taped a clean bandage over his stitches, he told me with a swagger, "Don't go to sleep because the guy who did this to me is going to be in here in about an hour and you'll get all the practice stitching you need!"

I chuckled and went to bed, but I was filled with a sense of foreboding. Technically speaking, my work was finished. In the crisis-driven atmosphere of the emergency room, a doctor's job is to "stitch 'em up and send 'em out." That response, though medically correct, seemed woefully inadequate.

Suppose the patient had arrived in the emergency room after taking an overdose of barbituates. We would have lavaged his stomach and then, if we were successful, we would have declared him medically stable. Our job would not have been done, however, until we had determined that he was no longer a threat to himself. Had he said, "Don't go to bed, because I am going home to take more pills," we would have been required to intervene. Standard practice mandates that a mental health provider be consulted when a patient is at risk for suicide. Moreover, if a patient appears to be a danger to himself, his physician has the medical and legal power to order a ten-day hospital stay for observation—even if the patient objects.

My emergency room patient was threatening to harm someone other than himself. Despite the fact that his anger imperiled many lives (including his own), I had no medically-recognized options. There was no standard practice mandating that I intervene. There was no prescribed treatment for anger that might explode into violence. I had no way to protect my patient or the community from an

outburst of rage I had every reason to suspect would be deadly. Anger and violence were outside my jurisdiction.

In the weeks and months that followed, I thought a great deal about this patient and other young males like him. I wanted to understand the forces that sent so many of them to the emergency room—cut up, shot up, bleeding, and dead. Why were so many young males striking out with knives and guns? What could be done to stop the carnage? These questions motivated me to learn about violence.

I learned that this country has many more assaults and murders than any other industrialized nation, and that most of these incidents occur among the poor.* I learned that violence takes the lives of thousands of our young each year; that homicide is the leading cause of death of young black males and the second or third leading cause of death (depending on the year) of young white males. I learned that half of all the victims of homicide are African-American, which is astonishing when you consider that blacks constitute only 12 percent of the American population.

The more I learned, the more perturbed I became. I could not understand the blindness of my profession. How could doctors ignore a problem that killed and maimed so many young, healthy patients? I knew that physicians spend a great deal of their time trying to prevent what are called behavioral illnesses—heart disease, suicide, obesity; conditions that result from a patient's own behavior. Yet violence, a grievous condition that surely stemmed from behavior, was overlooked. Why? Could the lack of interest be related to the race and economic status of the victims? Could it be that no one really cared about the pointless deaths each year of thousands of young men, most of them poor, half of them black? Well, I cared. I had a new son, a beautiful black baby boy with whom I was already madly in love. To me the lives of young males, black and white, were not expendable.

I began to ponder ways that medicine could intervene to reduce the number of young victims of violence. I was looking for an approach that would provide an unexplored perspective. My thinking centered on public health, the area of medicine most concerned with education and prevention. Twenty thousand homicide deaths a year convinced me that violence was a public health problem. To me it seemed self-evident: an "ailment" that killed so many ought to have the full attention of physicians and others concerned with improving health.

Seniors at Harvard Medical School were required to do special projects. For mine I decided to create a public health intervention to

* References throughout will be discussed in the Notes section following the text.

combat adolescent violence. My "intervention" was educational. I created a violence prevention curriculum to teach young males at risk for violence that they *were* at risk for violence, and to introduce them to ways of managing anger constructively. That early piece of work was far from complete. I still had a great deal to learn about violence, but at least I had made a start. Later I would refine this course and teach it in two of Boston's troubled high schools. A much later version of the curriculum was eventually prepared and marketed, and is now being used in schools in 324 cities in 45 states, as well as in Canada, England, Israel, and American Samoa.

Designing the first version of the curriculum forced me to find out about different disciplines that have traditionally been concerned with interpersonal violence. There were at least three separate professions to be considered—criminal justice, mental health, and the biological sciences. I needed to know what each of these disciplines could teach me about violence and violence prevention, and I needed to figure out where my thinking diverged from that of the experts in each of these fields.

Criminal justice is the vast mechanism created by local, state, and federal governments to apprehend criminal suspects, adjudicate their guilt or innocence, punish (and perhaps rehabilitate) the guilty, and eventually oversee their reintroduction into society. Police officers, prosecutors, judges, lawyers, forensic psychiatrists, prison officials, prison guards, and probation officers are all part of the criminal justice establishment.

Our criminal justice system is the offspring of English Common Law. Fundamental to this ancient code is the assumption that when a crime occurs there is an assailant who is guilty of the crime and a victim who is innocent. The job of the criminal justice system is to find an appropriate criminal suspect for every crime, to determine his guilt or innocence without trampling his constitutional rights, and, if he is found guilty, to punish him. In contrast to the idea of punishment, the far more modern and controversial idea that convicted criminals can and should be rehabilitated during incarceration is an idea to which our society has only occasionally been committed, although there is some evidence that rehabilitation programs can reduce rates of recidivism among young offenders.

Many people who work within the criminal justice system believe that punishment, in addition to being an appropriate social response to major offenses, serves as a deterrent to crime. They see punishment, if swift and sure, as a form of crime prevention. This is an idea that is passionately defended, but difficult to prove. I very much doubt that it is true. Today we have more people in prison than ever before. If punishment were a deterrent, then the number of crimes being committed in our society ought to be declining. FBI statistics indicate just the opposite.