Author's response to reviews

Title: How many Slovenian Family Practice Attendees are Victims of Intimate Partner Violence? A Re-evaluation Cross-sectional Study Report

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Research article

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The authors are grateful for the comments from both the Editorial Office and Reviewers.

I Authors’ answers to the Editorial Comments:

1. Abstract: ‘Decision maker in family medicine’ should be changed to ‘family medicine practitioners’
A: Decision makers on the policy, guidelines etc. in family medicine are not really the practitioners themselves; the decision makers are the professional bodies related to the Ministry of Health, therefore the sentence should not be changed or the meaning will be lost.

2. Background: Sentences should not start in figures replace with words
A: Done (pg 6 and 7) and marked yellow in the MS file.

3. Last sentence of the background is too long and should be recast
A: Done and changed:

Despite the high prevalence of DV, and the proven harmful consequences to health, there is still no consensus on prevention strategies for IPV in family medicine or in Slovenia in general. The present study aimed to re-test the prevalence data and provide sufficient grounds for decision-makers in family medicine to adopt much-needed protocols for IPV management in the field.

4. Methods: Define who a GP is? This term varies between countries. Level of training? Any specialization following initial medical training?
A: Specialization in family medicine in Slovenia was adopted in 2000. It takes four years, of which two years are the clinical rotation and the other two years the ambulatory-modular part. Specialization in family medicine (as well as other medical fields of specialization) is organized and coordinated by the Medical Chamber of Slovenia, particularly in clinical work in outpatient-modular work, with the Department of Family Medicine at the Faculty of Medicine actively participating. At the Department of Family Medicine, two days a month there are interactive educationally designed modules with topics that are specific to the profession of family medicine. The other days of the month the trainees work in family medicine clinics under the supervision of mentors.
In the text (pg 6):
In January 2012, there were 958 family physicians (general practitioners (GPs)), i.e., family doctors who finished four years of specialised training, registered in Slovenia.

5. Please give more details how the systematic sampling was done. Describe the procedure.
A: The Participants part of the Methods section was divided into Participants: GPs and Participants: Patients sub-sections.
Within the Participants: GPs subsection, the systematic sampling is now described as follows:
This cross-sectional study aimed to test the results of a study performed in 2010 [16] which focused on the diversity and geographical representation of family care settings as described by Svab et al [17]. Within the selected family care settings in 2010, it was mostly those GPs already aware of IPV that participated. The goal of the present study was to avoid a biased approach and include GPs regardless of their concepts and attitudes towards IPV management in family medicine; it was therefore decided to systematically sample the GPs to negate their possible different attitudes toward IPV.
In January 2012, there were 958 family physicians (general practitioners (GPs), i.e., family doctors who have finished four years of specialised training) registered in Slovenia. Every tenth GP listed in the Register of Family Medicine Doctors held at the Medical Chamber of Slovenia was invited to participate in a multi-centre study. After a two week recruitment period, 90 GPs (9.4% of all registered), working in 90 family practices all over the country, agreed to participate and were given written instructions about the approach to the patients, data collection and the provision for possible further help.

6. The comparison between this study and other studies should be moved to the discussion section
A: The comparison is made in the Discussion section. Part of the Methods section aims to emphasize the fact that the participating GPs were not biased and therefore the authors believe it should stay in this section – it is about procedure and sampling, not about the outcomes of the study. All other text was moved to the Discussion section (pg 11):
In comparison to a representative sample of Slovenian family practice attendees [17], in our sample there were more women (62.9% vs. 54.8%) and the mean age was slightly younger (49.0±16.1 years vs. 51.7±19.0). The predominance of women may have affected the gender distribution of violence in the sample.

7. The question assessing experience of psychological violence did not specify partner but rather stated family. Question may need to be adapted if instrument is to be used for other studies. The siblings, cousin, relatives are also family but not the focus of the study.
A: This was the third question in a row, it was explained to the participating patients that all questions focus on the intimate partner as a perpetrator. The expression in the original text was not as clear as it could be, therefore it was changed to:

(Pg 8) Psychological violence was screened for by asking In the past five years, have you been humiliated, subjected to threats, insult or intimidation, or in any way emotionally affected by your intimate partner?

8. Apart from approval for the study, what other ethical considerations were made? What happened to victims of violence who were identified from the study?
A: As stated in the manuscript, the National Medical Ethics Committee of the Republic of Slovenia approved the protocol of the study. No further ethical considerations were made.
Pg 8: The interview ended with an invitation to the patients to add or ask anything aside from the three stated questions. Of all those interviewed, 96 (3.7%) patients asked for a special IPV-related consultation.
Since the study design did not include a follow-up, the authors are not aware of any further procedures relating to the identified victims of IPV.

9. Results: The first four lines of the results is not socio-demographic information and should be moved elsewhere.
A: The first four lines:
The prevalence of only psychological violence in the sample was 10.3% (n=266), and that of concurrent physical and psychological abuse was 6.8% (n=174). All the patients exposed to physical IPV disclosed concurrent psychological violence. Of the sample, 17.1% (n=440) people were exposed to either just emotional or both physical and emotional abuse.
were moved above the Demographic Characteristics of Patients sub-title.

10. Copyediting: After reading through your manuscript, we feel that the quality of written English needs to be improved before the manuscript can be considered further.
If the Editorial office still wasn’t satisfied with the quality of written English, the authors would like to ask for these specific examples of English you thought needed improving.

11. Please also ensure that your revised manuscript conforms to the journal style (http://www.biomedcentral.com/info/ifora/medicine_journals ). It is important that your files are correctly formatted.
A: Checked. The original MS was submitted using the BMC template.
II R#1: Reviewer's report:
Answers to R#1 Comments:
Minor Essential Revisions
1. Refine the wording, that it will be clear if you write in this paper solely on partner violence men towards women or in both directions.
A: Done wherever the content permitted. However, previous studies performed in Slovenia, described on pg 5, were not focused in their design exclusively on IPV, therefore in several sentences the expression “domestic violence” (DV) remains as more suitable and valid.

2. Family clinic should read family practice.
A: Changed within the text and marked yellow.

3. There are some minor typo errors.
A: Corrected

III R#2: Reviewer's report:
Answers to R#2 Comments:
Minor Essential Revisions
Abstract:
1. Add to the methods that this was a cross-sectional study.
A: Done and marked yellow.

2. Move the response rate to the results.
A: Done and marked yellow.

3. Add a brief description of a sample to the results (gender, mean age).
A: Done and marked yellow.

4. This sentence is not crucial for abstract and could be removed: In multivariate logistic regression modelling, the associations between concurrent physical and psychological IPV, only psychological abuse, physical and/or psychological IPV, and the demographic characteristics of the patients were explored.
A: Done.

5. Conclusions are partly not based on the results. You did not study the effect of IPV-related education on the management of such patients. Please, adjust accordingly.
A: Done and marked yellow, emphasizing the detection and actions needed to be taken, since the prevalence data has been validated:

In Slovenian family practice attendees, an IPV exposure prevalence of approximately 17% should be considered a valid estimation. To improve both the diagnostic and treatment plans for these patients by detecting victims of abuse in a variety of clinical situations, empowering GPs by IPV-related education and comprehensive training would be of utmost importance.

Methods:

6. Add to the methods that this was a cross-sectional study.
A: Done and marked yellow.

7. First paragraph of the methods, 3rd to 6th sentence: this part would better fit to the discussion about methodology.
A: It was changed (pg 6).

8. It is not clear who explained the study to the participants and who gained their informed consent. Please, add.
A: Done and marked yellow.

The participating GPs asked every fifth family practice attendee, regardless of gender, aged 18 years and above, who had visited their GP for health problems, and who were given a physical examination, to participate in the study. After the study aim was explained, the subjects were told that participation was not obligatory.

9. The part about the data collection is a bit unclear. You stated that you performed the interview. Who performed it – the GPs? Also, you stated that you used a scale. Did the patients filled in this scale by themselves after the interview or was this scale also a part of oral interview? Please, add this to the text.
A: In the Participants: Patients subsection it is described as follows (pg 8):
The Domestic Violence Exposure Questionnaire used in the 2010 study [16] was administered by the GPs after the examination and consultation about the health problem that was the reason for attendance.
And also (pg 8):
The interview was ended by the GPs’ invitation to the patients to add or ask anything else.

The instrument used was a short form Questionnaire which was described in one of our previous publications; it is also described in the Measures section (pg 8):
The short form of A Domestic Violence Exposure Questionnaire, described by Kopcavar-Gucek et al [16] and developed in previous studies in Slovenian primary care [12,14], was used to test the prevalence of IPV in family medicine attendees. It consisted of
questions about gender, age, number of children, marital status, number of divorces, place of residence, and exposure to violence (psychological and physical, including coerced sexual intercourse).

10. The discussion about the demographic characteristics of the sample would also better fit to the discussion section.
A: Done and marked yellow (pg 11).

In comparison to a representative sample of Slovenian family practice attendees [17], in our sample there were more women (62.9% vs. 54.8%) and the mean age was slightly younger (49.0±16.1 years vs. 51.7±19.0). The predominance of women may have affected the gender distribution of violence in the sample.

11. Last sentence in the paragraph Measures should be moved to the paragraph Data analysis.
A: Done and marked yellow (pg 8).

In multivariate logistic regression modelling, the associations between concurrent physical and psychological IPV, psychological abuse only, and physical and/or psychological IPV, all considered as the dependent variables, and the demographic characteristics of the patients, i.e. the independent variables, were explored.

Results:
12. In the first paragraph of the results you should add also absolute numbers (now you have only percentages).
A: Done and marked yellow (pg 9).

The prevalence of only psychological violence in the sample was 10.3% (n=266), and that of concurrent physical and psychological abuse was 6.8% (n=174). All the patients exposed to physical IPV disclosed concurrent psychological violence. Of the sample, 17.1% (n=440) people were exposed to either just emotional or both physical and emotional abuse.

13. Figure 1 is not mentioned or referred to in the text of the Results. Please, add.
A: Done and marked yellow (pg 11).

Major risk factors for IPV exposure are presented in Figure 1.

Conclusion:
14. Conclusions are partly not based on the results. You did not study the effect of IPV-related education on the management of such patients. Also, you did not study the prevalence of missed opportunities by GPs to detect abuse victims. Please, adjust accordingly.
Given that, GPs might often have been missing opportunities to detect victims of abuse in a variety of clinical situations. The detection of domestic violence by GPs might alter both the diagnostic and treatment plans for these patients. However, dealing with patients suspected of being physically abused, sexually abused, or involved in other violent acts was the least common ethical dilemma (<0.1%) among Slovenian GPs [23]. On the other hand, in a study aiming to determine the prevalence of difficulties in managing ethical dilemmas in Slovenian family practice, Klemenc-Ketis et al [24] found the most difficult ethical issues for GPs were abandoned and unattended patients and patients with insufficient means of support (48.6%), as well as suspicion of physical abuse, sexual abuse, or other criminal behaviour exposure in patients (40.9%).

The Conclusions, based on the Results and the Discussion, were adjusted as follows: An approximately 17% prevalence of IPV exposure in Slovenian family practice attendees leaves no doubt about the seriousness of the problem. It is therefore of the utmost importance that family medicine professionals receive proper IPV-related education and comprehensive training, to enable them to understand and recognise IPV and its health effects on their patients. Aside from facilitating GPs with training, professional policies are needed. Therefore, in family medicine in Slovenia, it is necessary to introduce and develop IPV-related referral resources, policy guidelines and protocols.

References:
15. There are some Slovenian studies on ethical dilemmas encountered in family practice which include the prevalence of dilemmas of abuse. Please, include them to the text.
A: Done and marked yellow on the References list: