Author's response to reviews

Title: Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses

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Version: 2 Date: 17 November 2006

Author's response to reviews: see over
Re MS: 1812189519114007

We wish to re-submit our revised manuscript, entitled “Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses”, for consideration as a research article in BMC Public Health.

We wish to thank both reviewers (Dr. Amy Bonomi and Dr. Therese Zink) for their helpful comments and suggestions on the original manuscript. Please find below our point-by-point response to the reviewers, outlining how we have addressed their recommendations in this revised version of the paper.

Formatting changes have been made to the manuscript. Author qualifications have been removed from the title page. Also, unnecessary capitalization was removed from subsection headings. References were reviewed and now contain all named authors, regardless of the number. Finally, an additional file has been added to the document that includes the case scenario used in the study questionnaire.

And, the manuscript now includes a statement in the Methods section on informed consent.

Thank you for your consideration.

Sincerely,

Iris Gutmanis

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cc: Charlene Beynon, Leslie Tutty, C. Nadine Wathen and Harriet L. MacMillan
Authors’ response to reviews

Re MS: 1812189519114007

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Version: 2   Date: November 16, 2006

Author’s response to reviews: see over
Response to comments from Dr. Amy Bonomi

Major Compulsory Revisions
NONE

Minor Essential Revisions

1. The introduction and discussion would benefit from a more systematic review of other studies and papers that have addressed IPV screening barriers and facilitators reported by medical professionals.

The three papers that come immediately to mind are as follows:
Sugg & Inui (JAMA):
Sugg, Thompson et al. (Archives of Family Medicine):
Gerbert et al. (Annals of Internal Medicine):

For the introduction, what will your study address that these prior studies haven’t? For the discussion, what does your study add above and beyond what these other studies found? There may be other studies since these and I suggest that the authors attempt to identify and cover these in their paper.

We have added to the Background section a summary of additional studies that are examples of the types highlighted by the reviewer (including the specific ones suggested). There are dozens of related studies, so we have tried to summarize the key aspects of these, as a group, that relate to the paper. Some of these, and more, were already in the Discussion (again, grouped to summarize the key points) and we had commented on how our findings confirm and/or extend previous work. We thank the reviewer for pointing this out, as there is now more balance between the Background and Discussion sections re: literature reviewed.

2) It would be beneficial to readers if you provided a brief description (even in parentheses) about what Scott’s Directories are.

A brief description of this data source has been added to the first sentence of Methods, Study sample.

3) I’d like more description of the questionnaire development and administration process. How did the investigators decide on their final list of 43 questions? What did the practice scenario with “Carol” comprise? Were the questions that followed the hypothetical
scenario describing the situation with Carol asking respondents to say what they would do in response to Carol, or in response to IPV as it “typically presents” in medical practice?

Further description of the questionnaire development process and the administration process has been added. In addition, the complete practice scenario and instructions for questionnaire completion are now included (see Additional file 1).

4) Methods --- I would move your description of how you examined construct validity from the results section to the methods section. When I first read the methods, I was scratching my head about how you actually examined construct validity. It wasn’t until I got the results that I was able to see what you did.

The description of how construct validity was determined has been moved to the Methods section.

5) Methods --- on page 8, if eigenvalues exceeded one and the scree plot suggested more than one factor, how did you reallocate questionnaire items to different scales?

A sentence has been added to the data analysis section stating, “if eigenvalues exceeded one and the scree plot suggested more than one factor, the proposed scale items were reviewed and reallocated to new scales based on item-item and item-total correlations”.

6) Methods --- why did you use forward regression (versus standard regression where all blocks were entered simultaneously), and with the forward regression how did you decide on the order blocks would be entered?

Forward hierarchical regression model building, as described in version 1 of the paper, is often used for hypothesis testing. The researcher enters the independent variables in a specific order, usually according to logical or theoretical considerations. No theoretical or logical considerations were provided in the text nor could any be found in the literature. Thus, hierarchical forward regression modeling should not have been used.

Instead, the current version describes how exploratory linear regression models were built using forward, backward and stepwise procedures. Further, irrespective of the analytical strategy, the same independent variables were identified as being significantly associated with the dependent variable, preparedness.

7) Methods --- in the paragraph describing the regression methods on page 8, it would be useful if you clarified that the question “have you ever had to call the police due to a disclosure” meant had they called police for a disclosure in clinical practice. I’m assuming that’s what you mean, yes? Please clarify this on page 9 as well. It might not hurt to also remind readers on the bottom of page 9 that “personal experience with IPV” means their own individual experience or family or friend with experience.

As now indicated in the text, study respondents were asked, “Have you ever had to call the police due to a disclosure of abuse?” and “Have you ever had to call the Children’s Aid Society
(CAS) subsequent to a disclosure of woman abuse?”. In neither case did the question stipulate if calls to either the police or the CAS were related to clinical practice or personal experience. Clearly, in retrospect, the question should have been made specific to clinical practice. It has now been made clear to the reader that these questions did not mean that the respondent had called either the police or the CAS for a disclosure in clinical practice. This has been clarified both in the section describing the independent variables selected for the exploratory linear regression models and in the description of the model building results. Also, if the issue of personal experience with IPV, as it relates to this study, is discussed, the words have been changed to indicate that in this study, personal experience means respondent, friend or relative experience.

8) Results --- your finding on page 10 that physicians were more likely to initiate the topic of IPV, particularly if they work in the emergency department seems to get at an underlying dilemma with people’s interpretations of abuse in Canada and the U.S. Docs, for example, are trained (and/or come to learn by societal reinforcements?) to associate injuries and other acute trauma with abuse. However, what about the large proportion of depressed women presenting in primary care practice who are experiencing underlying abuse? Are they being screened at similar rates? Likely not.

No need to do anything here. I’m merely commenting.

We thank the reviewer for this interesting comment. This is certainly something that warrants further investigation.

9) Results --- also on page 10, it was encouraging that you found that docs who practiced for less than 10 years were more likely to ask about IPV than docs with 10 or more years of practice. It seems we may be doing an increasingly better job in medical schools to prompt physicians in training to screen for IPV ...?

Again, we thank the reviewer for a very interesting comment. We sincerely hope that medical schools are doing a better job in training physicians to screen for IPV.

10) Results --- page 10, which two items could you not assign to the eight constructs and why? Related to this, on page 11, I didn’t understand the sentence: “the constructs for the two previously problematic statements became clearer.” Please clarify.

The two items that originally could not be assigned to one of the eight constructs are identified. Two of the authors disagreed as to the allocation of these two items. One author could not allocate either item to a construct, while the other allocated both items to specific constructs. Both items were eventually allocated to specific scales following an examination of the item-item and item-total correlations. However, these two items were allocated to scales based only on statistical relationships.

11) Results --- I would move the descriptions of the eight constructs from page 11 to page 10 as follows “study investigators initially identified eight constructs: ENTER CONSTRUCTS HERE.”
We concur with the reviewer and the names of the constructs have now been moved to an earlier section of the paper.

12) Results --- second paragraph on page 11, I’d start by saying “as noted in Table 4, seven of the eight scales demonstrated acceptable internal consistency required for group comparisons.” Follow it by a brief sentence about the scale with the lowest alpha. You should also note that the scale with the lowest alpha of 0.59 comprised 3 items. Alpha naturally decreases with decreasing numbers of items within a scale. So it’s not that surprising that you might see a lower alpha with this scale. Also of note, some of the most well validated scales have a subscale here and there with lower internal consistency values (i.e., below 0.70). However, the developers have chosen to retain all items within the subscales because they represent important conceptual dimensions.

Thank you this suggestion. It has been incorporated into the paper.

13) Results --- on page 12, I don’t think you need to capitalize Violence Against Women. Also, you use many different terms to refer to violence against women in your paper. Did you use the term “intimate partner violence” in any of the survey questions? If not, why?

The term “Violence Against Women” is capitalized in the quotation, as this is how the question appeared in the survey tool.

A number of terms that refer to violence against women are used in the paper. As seen in Table 3, the words “woman abuse” or “abuse” were used in the survey tool. None of the items used the term “intimate partner violence”. As indicated in the methods section, the items primarily came from existing tools, particularly work by Dickson and Tutty and Moore et al. In both tools, the term “woman abuse” is used. As some of the items for this tool were taken verbatim from these tools, the authors decided to consistently use the term “woman abuse” throughout the survey instrument.

14) Discussion --- page 16, you suggest that your findings “enhance and extend those of previous studies that have examined clinician attitudes and practices specific to IPV identification and intervention” yet you don’t provide references. Please do. Also, please note my earlier comment that you consider a more comprehensive review other studies that examined these issues. What does your study add?

As described earlier, we have added in the Background section additional studies that provide good examples of the types of studies available on the topic, and a more detailed list of their main findings. These references have now been added to the Discussion at the end of the paragraph indicated by the reviewer.

15) Discussion --- page 18, last paragraph, you say: “further studies using models that examine self-efficacy are warranted.” Could you provide a couple of examples?
The statement about future research on self-efficacy has been deleted. Although examples could be provided, the authors felt that as this was not a focus of the paper (no literature dealing with self-efficacy has been described), this comment could be deleted without jeopardizing any study findings and conclusions. In addition, this deletion was a way to shorten the paper (see comment below).

16) In general, the paper could be shortened by a quarter. I realize I am saying this while also suggesting that you add more detail. However, I think it can be relatively easily done.

Although the paper has not been shortened by a quarter, the section describing the hierarchical model building has been deleted. In addition, as described above, the discussion section was shortened.
Response to comments from Dr. Therese Zink

Major Compulsory Revisions
None

Minor Essential Revisions
None

Discretionary Revisions

1. It would be nice to include the practice scenario—perhaps in the appendix.

The practice scenario and the questionnaire instructions are now part of the paper (see Additional file 1).

2. What were the open ended questions-please include.

The open-ended questions have now been added to the description of the study questionnaire.

3. Open ended questions: It would be interesting to know more about the responses. Probably no space in this article. But perhaps qualitative analysis for another manuscript.

We are currently finalizing a paper summarizing the responses to the open-ended questions and will be submitting this article to BMC Public Health within a few days.

4. You might want to call attention to the fact that the personal experience is almost half of both groups. That may be the result of those interested enough to fill out the survey, but it also points out the prevalence of this issue.

A sentence relating to this point has been added the first sentence of the second paragraph in the discussion section.

5. However, I think the discussion and recommendations fall short: Given the limited attention to IPV in the curriculum, ref 22 and the expectation of patients/victims that providers understand IPV ref 32 and 60% of respondents not having had any education, you may want to include the importance of addressing the educational needs on a larger scale. Based on your finding the curriculum should be more than a lecture but needs to address the issue of preparedness that you identify—having talked with abused women. This suggests formats that might include partnering w/ advocacy agencies to create learning opportunities to fill this deficit. It is time to integrate IPV into health care curriculum and continuing medical and nursing education as part of the mainstream. Calling for more research is inadequate at this point. There has already been a lot of research on provider screening rates and inadequacies.

We completely agree with the reviewer’s comments, and have added as much in the final line of the conclusions.