Reviewer's report

Title: Intimate Partner Violence in Women with Musculoskeletal Injuries

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Reviewer: Amy Bonomi

Reviewer's report:

Thank you for the opportunity to review this interesting and important paper. The paper addresses an important topic—what is currently known on studies related to intimate partner violence (IPV) in orthopedic settings. My main concern about the paper is its contribution above and beyond what we already know to be the problems with IPV screening and response in health care generally; namely, existing studies have already shown that IPV is prevalent, results in adverse health consequences and elevated health care costs, and problems exist around 1) physician biases/time/interest and 2) existing measurement approaches/tools and responses to IPV. I have a few suggestions for consideration. The most substantial concerns are that: 1) the Introduction be re-focused on extant issues in the orthopedic field, rather than a general overview of IPV-related health consequences and costs; 2) the Methods section include a significant expansion on the “how to” associated with the generic recommendations made for health care providers interacting with abused women; and 3) the authors provide a more definitive “what we should do” statement; a review of existing literature is provided to inform steps, but the steps could be honed even further by expanding upon the literature. The manuscript will be most effective for practicing clinicians and researchers interested in this area if more definitive “how to” information is provided.

Introduction:

• I suggest reorganizing the Introduction to tighten the focus/message, namely that the authors start with 1) describing the prevalence of IPV observed in orthopedic settings (from the section on “Knowledge Gaps …” – the manuscript doesn’t have page numbers, so I am referring to content areas), 2) orthopedic-related health consequences of IPV (from the section “Musculoskeletal Injury and Its Association with Intimate Partner Violence”), and then lead into the objective of the present paper. The general overview of IPV-related health effects and health care costs detracts from the paper’s focus on orthopedics. If the authors wish to “give a nod to existing information in the IPV literature more generally,” IPV-related health effects and health care costs could be covered in one introductory paragraph that transitions into the orthopedic focus.

• Following my first comment, I suggest an even tighter focus/expansion of why examining IPV in orthopedic settings is important. The authors state that there is “renewed interesting in underlying IPV risk in women with musculoskeletal injuries … has led to several important studies to determine the nature and scope
…” However, the authors don’t elaborate upon what those studies are; as well, there are only two studies cited despite the claim that there are “several important studies

• I appreciated the section called “How Can We Help IPV Victims in the Orthopedic Fracture Setting” … and believe that (from the above coverage of IPV prevalence and health effects in orthopedic settings) would be the ideal lead into the Methods, which covers biases, screening approaches, response approaches, etc.

• If the authors choose to retain the general overview of IPV studies, there are a few references incorrectly cited in the Introduction:


• There are other papers noting associations between IPV and adverse health that might be considered for referencing.

Methods/Review:

• An overarching concern I have when reading manuscripts that address what health care providers “should do” when interacting with women with abuse histories is that the manuscripts must say more about the “how to.” For example, the authors recommend the following: “If a patient does not wish to disclose about an IPV experience, the HCP should understand that it is the patient’s choice and not to force the conversation. Similarly, if the patient chooses to disclose but not take action (leave the relationship, accept referrals, seek counselling etc.), then the patient’s wishes should be respected…” This is “easier said than done.” What does the existing literature say might be helpful regarding the dynamics of abuse that could elucidate how interactions with women might go? There is a large body of literature discussing how to navigate biases, etc.

• Related to the above, I have two concerns about this statement: “IPV is very complex and following disclosure, an IPV victim may not be ready to leave their partner, potentially resulting in fear of seeking help …” 1) How is IPV “very complex?” and 2) The statement that “an IPV victim may not be ready to leave their partner” is biased; the literature suggests that, on average, women make
7-8 attempts to leave their abusive partner before they finally do. However, more importantly, leaving an abusive relationship is often not women’s first desire; many wish to stay in the relationship, but have hopes that the abuse will stop. This literature needs to be incorporated; otherwise, the manuscript reads like other prior manuscripts that “provide information” but don’t provide steps on “how to” or provide depth beneath the complicated issue of abuse.

• Again, related to the above, more information could be provided to support this statement: “The IPV Coordinator must be educated appropriately to help to provide IPV victims with the appropriate social support ....” Specifically, shelter-based studies such as those by Cris Sullivan (1998, 2002) show that linking women to an advocate who provides social support and helps women make other linkages results in improved outcomes over time compared to women who were not linked to an advocate — lower abuse rates, better quality of life, etc.

• And one more minor “again,” can the authors point to studies that have shown an efficient way to screen, since time constraints are cited as a major barrier?

• When discussing the performance of screening tools, it would be helpful if the authors noted up front that for a condition like IPV, it is more important to maximize sensitivity than specificity. It would also help readers if the authors included a sentence defining sensitivity/specificity. For some of the well-known screening tools, like the Abuse Assessment Screen (AAS), the authors suggest that prior studies have shown good specificity but compromised specificity. Again, for IPV, it is better to have good sensitivity than specificity.

• The authors make these statements about screening men for IPV: “Although, on the surface, it may seem fair to ask all men about IPV in addition to all women, evidence shows that women are disproportionately affected by IPV compared to men 31, 32, 33. Men are also less likely to admit that they are victims of abuse and less likely to seek help, making identifying IPV in men a greater challenge 34 ...” Does this substantiate a move to not screen men then? I believe more information is needed, even though the authors suggest that screening men may not be cost efficient. One issue is how to help men feel more comfortable discussing their experiences — what does the literature say about that?

• Finally, it seems that a significant obstacle in regards to IPV screening/response programs is how to ensure sustainability over time. There is literature from Wagner and colleagues (2001) on the Chronic Care Model, which was adapted for IPV (Nicolaidis et al., 2006). Also, please see Bodenheimer JAMA 2002 on the Chronic Care Model. The Chronic Care Model provides a framework for the health care system’s response to identifying and responding to chronic health care issues like IPV — including ensuring the sustainability of such identification/response programs. I wonder if you could consider incorporating some of that here?

**Level of interest:** An article of importance in its field

**Quality of written English:** Needs some language corrections before being
published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare I have no competing interests.