Clin Orthop Relat Res (2013) 471:1069–1073 / DOI 10.1007/s11999-013-2836-7

Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

Published online: 20 February 2013
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Editor's Spotlight/Take 5

Editor's Spotlight/Take 5: Orthopaedic Surgeons' Knowledge and Misconceptions in the Identification of Intimate Partner Violence Against Women. (DOI 10.1007/s11999-012-2749-x)

Seth S. Leopold MD

The American Academy of Orthopaedic Surgeons (AAOS) has a very explicit definition of intimate partner violence (IPV) [1]. So does the American Medical Association (AMA) [2].

I did not write them out here, though, because most of us believe we know what IPV is, and how to identify patients who have been injured by it. (For the curious, I have included them in parentheses at the end of this commentary).

It turns out we may not be right. Many of us, knowingly or not, harbor misconceptions about this scourge that impair our ability to identify the problem and help its victims.

Dr. Gregory Della Rocca and colleagues present results from their survey of the Orthopaedic Trauma Association (OTA) on this subject, and those results are troubling. More than 15% of survey respondents believed that the victims must be getting something from the abusive relationship, and one-fifth of respondents believed that some women have personalities that cause the abuse. Although more than half of the surgeons who responded to the survey have identified an IPV victim recently, 96% do not screen their female patients regularly.

One can quibble over the details of the paper—the response rate, for example, was somewhat low—but the data fit in very well with some previous publications on the subject [3, 4].

In the *Take 5* interview with Dr. Della Rocca that follows, we go behind the discovery and explore topics including how best to screen for IPV, to what degree cultural differences affect our ability to diagnose it, and steps the larger systems in which we work might take to reduce the harm it causes. So I urge you to read on.

But even more importantly, I urge you to familiarize yourself with IPV. The Academy's information statement, in particular, is worth a careful look. [1] It is entirely possible that, as an orthopaedic surgeon, you will be the first physician to have the opportunity to intervene, and your intervention can be lifesaving.

Note from the Editor-in-Chief
In "Editor's Spotlight," *one of our editors provides brief commentary on a paper we believe is especially important and worthy of general interest. Following the explanation of our choice, we present* "Take Five," *in which the editor goes behind the discovery in a one-on-one interview with an author of the article featured in* "Editor's Spotlight."

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(In case you are not familiar, the AAOS defines IPV as violence that "occurs between any two individuals with either a current or former 'close' relationship … It includes acts of rape, physical and psychological violence and stalking" [1]. The AMA's definition includes "repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation" [2].)

Take 5 with Gregory Della Rocca MD PhD

Lead Author of: Orthopaedic Surgeons' Knowledge and Misconceptions in the Identification of Intimate Partner Violence Against Women

Seth S. Leopold MD: *You have done considerable research on IPV. In your estimation, what three things should every orthopaedic surgeon know about it?*

Gregory Della Rocca MD, PhD: First, orthopaedic surgeons should be aware that IPV is almost certainly more prevalent in their clinics than they think. The survey revealed a disconnect between orthopaedic surgeons' perceptions of IPV prevalence in society and in their fracture clinics. This discrepancy is difficult to explain when musculoskeletal injuries are so common among victims of IPV. A recent prevalence study in two trauma centers found that one in three women who presented to fracture clinics with orthopaedic injuries experienced IPV in the past year. One in 40 women presented to the clinic for injuries that were the direct result of IPV. None of these women were asked about IPV by the attending surgeon.

Second, inquiring about IPV with female patients being evaluated in the setting of an acute injury is not an invasion of their privacy. Investigating the cause of a particular injury is part of a normal "history of the present illness." Physicians routinely inquire about alcohol and illicit drug use as part of their evaluations of injured patients, and also inquire about other factors (such as use of helmets for motorcycle crash victims and use of restraint devices for motor vehicle crash victims) that could contribute to the spectrum of a patient's injury. Therefore, questions about IPV represent logical inquiries, especially when the circumstances behind a patient's injury are obscure. Recent surveys have shown that the majority of patients in healthcare settings, including orthopaedic clinics, are supportive of screening for IPV.

Third, orthopaedic surgeons should familiarize themselves with resources available to victims of IPV. Half of survey respondents agreed with the statement, "I don't know what to do if I find an IPV victim." The implication of this may be that a surgeon's ignorance may itself represent a barrier to pursuing this important line of inquiry. Surgeons need to learn what resources are available, so that they are more likely to ask these important questions.

Dr. Leopold: *Some of the injuries associated with IPV are not visible on a typical orthopaedic examination and x-rays. Given that, how do you and your colleagues screen for IPV in your practices, and whom do you screen? What approaches can you recommend for nontraumatologists?*

Dr. Della Rocca: Screening for IPV in fracture clinics begins with a basic knowledge of IPV prevalence, and a suspicion that any injured female patient may be a victim of IPV. Female patients injured under obscure circumstances warrant investigation similar to that which occurs when children or elderly adults are injured under obscure circumstances. The orthopaedic trauma community and orthopaedic surgeons in general may benefit from discussions with physicians who treat injured children, in particular, to elucidate ways to approach potential female victims of IPV.

Some symptoms associated with IPV victims are indeed not part of the

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orthopaedic history, physical examination, and radiographic examination. Data from our survey (which was not presented in the manuscript) indicated that approximately half of respondents' are of the opinion that inquiring about headaches and irritable bowel syndrome, often reported by female IPV victims, was not part of the "role responsibility" of the respondents. Chronic pelvic pain, depression, anxiety, and hypertension also are associated with IPV, and yet nearly 50% of respondents never inquired about IPV among female patients reporting any of these symptoms. All of the listed symptoms form a routine part of a 14-point "review of systems"—a normal component of a complete new patient history and physical examination. Surgeons should familiarize themselves with the association of these symptoms and IPV.

A major issue with IPV screening is that we do not currently have a sensitive or specific model of what presenting symptoms or characteristics an IPV victim may have when she presents to a healthcare provider. Perhaps because of this, surgeons and others who screen for IPV may be biased in terms of who they believe is more likely to be a victim of IPV and, therefore, this may affect whom they screen for IPV. Asking every female patient about IPV in orthopaedic clinics would eliminate this bias. This approach could be accomplished using an advocate model, where a staff member who is specially trained in IPV screening and management speaks to every female patient privately about IPV, eliminating many of the barriers that surgeons face, such as lack of time and not knowing how to deal with IPV cases, when identified. This approach is analogous to the approach some trauma centers have used to manage osteoporosis more effectively. Some trauma centers in Ontario, Canada, and the United States, including the University of Missouri, have osteoporosis coordinators who talk to all high-risk patients about osteoporosis management, and these programs have resulted in substantial success with improving treatment of osteoporosis patients.

Dr. Leopold: *You've studied IPV at numerous levels—regionally and nationally in Canada, and now through a specialty society that has an international membership. Have you noticed any important similarities or differences when you evaluated the different populations?*

Dr. Della Rocca: Importantly, the bulk of respondents (96%) for the survey presented in this manuscript were from North America (Canada and the USA). So from this survey, we could not clarify differences between these and other countries. The results presented here are similar to those from the survey of the Canadian Orthopaedic Association by Bhandari and colleagues [4]. As our survey included Canadian members of the OTA, we really could not say whether differences exist between Canadian and United States orthopaedic surgeons in their perceptions of IPV among their female patient populations.

Dr. Leopold: *On the subject of cultural competence: To what degree, if at all, do you believe that gender, racial, ethnic, or nationality differences between provider and patient affect the likelihood that a surgeon will identify a victim of IPV?*

Dr. Della Rocca: Victims of IPV are more likely to admit to a history of IPV if they are interviewed separately from their companions during clinic visits. In certain cultures, female patients nearly always are accompanied by a male spouse, family member, or guardian. It is possible that they will not allow themselves to be separated from that individual during the interview and examination portion of the visit, especially if the healthcare provider is an unrelated male. Numerous respondents to our survey indicated that asking batterers about IPV will increase victim risk and that there is no way to ask batterers about IPV without putting the victim in danger. A logical extension of this would be a reluctance to inquire with potential victims if they are accompanied by a (male) significant other or family member, as this may decrease the likelihood that the

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victim will admit IPV even if it does exist and increase the victim's risk as a consequence of the potential batterer's having heard the line of inquiry.

Perhaps female healthcare providers may be more successful at elucidating a history of IPV from injured female patients. It is possible that patients may be more forthcoming when questioned by a female provider. IPV victims also may feel threatened by a male provider, perhaps further reducing responsiveness. Also, a female provider may have more success in separating a female patient from her (male) companion(s) for a physical examination, during which inquiries about IPV may be made. Having an IPV advocate available in orthopaedic clinics, as described above, also may help with overcoming this barrier.

All of the above notwithstanding, the cultural background of the female IPV victim also may reduce their responsiveness, even under ideal circumstances. Female members of societies where IPV may be endemic may be unwilling to share a history of IPV with a healthcare provider. Elucidation of these barriers to identification of IPV victims represents an important area of future research.

Dr. Leopold: *Taking the wider view for a moment, how can we tackle this problem at the systems level? Are there specific interventions you believe specialty societies, training programs, journals, or government entities can take that would reduce IPV-related injuries?*

Dr. Della Rocca: Our survey revealed a gross underestimation of the prevalence of IPV among providers in fracture clinics. So the first step is increasing awareness of the problem. The AAOS is well positioned to champion this. Formal symposia and/or instructional courses may be beneficial for jump-starting the educational process for orthopaedic providers. Subspecialty societies, which are smaller in size, can have society-wide symposia presented at their annual meetings which reach all participants in a general session; the AAOS meeting is just too large for a general session to reach all members. OTA meetings, in particular, could be good venues for this because of that society's mission regarding the treatment of patients with musculoskeletal injuries.

The Accreditation Council for Graduate Medical Education (ACGME) in conjunction with the American Board of Orthopaedic Surgery (ABOS) can work to establish minimum competencies regarding domestic violence for orthopaedic trainees and orthopaedic surgeons seeking certification and recertification. Since investigating the cause of a patient's injury represents a universally accepted part of any history and physical examination, responsibility for assuring awareness of the problem and of intervention methods should fall to the physician/surgeon community itself. It is a matter of professionalism.

We discourage approaches involving government regulation at the state or federal level. Rather, we endorse lobbying efforts by our orthopaedic associations and societies, such as those now underway in Canada, which seek to increase governmental awareness of IPV prevalence and its consequences. Specialty societies have a sterling and timely opportunity to steer this effort.

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