



Intimate Partner Violence and Best Practice Recommendations

A Position Statement from the Canadian Orthopaedic Association

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Canadian Orthopaedic Association

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The Canadian Orthopaedic Association (COA) recognizes that intimate partner violence (IPV) is a significant social determinant of morbidity and mortality, and that orthopaedic surgeons are well positioned to identify patients living with IPV and provide assistance. Therefore, the COA encourages its members to educate themselves further about IPV and considers it good medical practice to take steps to identify and offer assistance to victims.

Background

IPV, spousal abuse, domestic violence and domestic assault are just some of the commonly used terms that describe a complex set of behaviours, where one partner abuses the other verbally, physically, sexually, emotionally or financially. Most often, IPV is committed by men against women; indeed, IPV is the most common form of violence experienced by women — although women do abuse men, and IPV can occur in same-sex relationships. Compared to males who are victimized by IPV, female victims are more likely to experience more severe forms of violence and are more likely to fear for their lives. Women from all income and education levels, social classes, religions, racial groups and cultures experience IPV. Globally, 1 out of every 3 women who have ever been in a relationship has been victimized by IPV.

Police data suggest that women aged 25 to 34 experience the highest rates of IPV. In Canada, 25% of abused women report episodes of being beaten, 20% report strangulation, and 20% sexual assault. Physical injury is reported by 40% of abused women, and 15% require medical care for their injuries. Health Canada has reported that 21% of abused women surveyed reported violence during pregnancy, and 40% of these women said that the violence began during pregnancy. Often, violence escalates after the baby is born. IPV is a risk factor for intimate partner homicide and 38% of all murders of women are committed by intimate partners. Previous research has found that 45% of women who are killed by their intimate partner have attended a hospital for treatment of IPV-related injuries in the two years preceding their death. A prospective cross-sectional study of women attending fracture clinics found that 35% of women had been victimized by IPV at some point in their lives and 16% in the past year. Additionally, 2% of women were attending the fracture clinic for treatment of an injury that was a direct result of IPV.

It is important to note that many patients experiencing IPV will not present with any outward signs or symptoms of abuse. However, if patients do present with signs or symptoms of abuse, they are likely to be ill-defined, with multiple injuries, often sustained indoors in a domestic setting. Physical injuries from IPV tend to be central — face, head, neck, breast and abdomen. Head and neck injuries are the most common: concussions, black eyes, fractured nose, fractured jaw, broken teeth, and fractured skull. Musculoskeletal injuries are the second most common: sprains (back, neck, wrist, ankle, foot), dislocations (shoulders, fingers), fractures (fingers, humerus, pelvis, foot). Injuries to the torso include fractured ribs, bruising and epigastric tenderness. Skin injuries range from bruises, scratches and lacerations to burns, bite wounds and stab wounds. Escalating severity of physical violence is a risk factor associated with intimate-partner homicide.

It is important to ask about IPV in the emergency room and fracture clinics because asking this question conveys that health care professionals view IPV as an important health issue and that they are open to discussing it and providing assistance. Disclosure depends on a number of

factors: the patient's physical/emotional readiness, the type of clinical setting, feelings of safety in the setting, and a sense of trust in a particular caregiver. The reasons for non-disclosure are numerous and often complex. Upon disclosure, priorities for some women may include immediate care for their injuries, concern about their own safety as well as the safety of their children or other family members, and inability to develop a bond of trust with treating physicians.

Follow-up visits to the fracture clinic (where research suggests as many as 1 in 6 female patients have been victimized by IPV within the past 12 months) or to the surgeon's office provide opportunities to develop a stronger surgeon/patient relationship. In these settings, it is important to ask women about IPV regularly (not just at the time of their initial visit). Women may not feel ready to disclose IPV the first time they are asked, but may be ready to disclose at a subsequent visit if they are asked again. Confidence and trust may take time to develop, and often requires that the patient hear the same message of concern in a range of different settings from the emergency room to the doctor's office. Asking about IPV is as much about communicating the possibility of help as it is about screening for victims. Research into patients' feelings about being asked about IPV has found that the majority view the fracture clinic as a good place to ask about IPV and believe that it would be easier for IPV victims to get help if fracture clinics asked about abuse.

Roles and Responsibilities of Orthopaedic Surgeons

In Canada, physicians are not legally obligated to report abuse of adults to the police unless the abuse comprises the welfare of a child. Women's IPV disclosure is a voluntary act, and, therefore, the decision to disclose or not disclose must be respected. However, IPV disclosure is almost never spontaneous. In qualitative studies, women have said that being asked about IPV helped them to recognize the problem, break their silence, validate their feelings and instilled in them a desire for change. For an intervention to succeed, privacy and a sense of compassion are paramount. Waiting room posters and patient literature offering local services help to normalize the disclosure of domestic violence. While IPV may be first recognized in a medical context, a positive resolution for an abused woman may involve social, legal and, child protection services. Thus, a continuum of care should be developed to help patients gain access to appropriate community social services for counseling and local women's shelters for additional support and protection if needed.

To be effective in helping victims of IPV, the health-care teams in the emergency room and fracture clinic need to feel they have the support of colleagues and hospital administrators. Ideally, these health-care providers should receive training in caring for patients who experience IPV (e.g. trauma-informed practice), and they should have easy access to community-based social-service networks.

Surgeons and designated health-care professionals in the emergency room and fracture clinic should have the following contact information readily available:

- Hospital-Associated Domestic Violence Care Centres (see Appendix)
- Social workers on call for hospital emergency departments and ward/clinic settings
- Community-based shelters
- Toll-free help-lines for domestic violence
- Print materials that reflect Canada's cultural diversity

Asking the Question

Surgeons and other health-care professionals interacting with women in emergency rooms, fracture clinics or office environments should conduct their assessment for IPV in a private setting, without the partner or other family members present. Asking direct questions about abuse tends to elicit direct answers, although surgeons should feel free to phrase the question to suit the immediate situation.

Here is a suggested approach using a clinically validated screening tool:

- Set the context with a lead-in question: *“Because violence is so common in many women’s lives and because there is help available, I now ask every patient about domestic violence.”*
- Follow up with the Partner Violence Screen, which consists of three quick questions designed to detect past physical violence and perceived personal safety:
 - “Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom?”*
 - “Do you feel safe in your current relationship?”*
 - “Is there a partner from a previous relationship who is making you feel unsafe now?”*

First and foremost, surgeons must respect a woman’s choice not to disclose suspected IPV. Under such circumstances, doing no more than providing immediate care may be the only option.

Suggested Steps After Disclosure

When a woman does disclose IPV during examination, surgeons and designated health-professionals should consider doing the following:

- Validate her feelings, by telling her that the abuse is not her fault. Be nonjudgmental, empathic and supportive throughout the interaction. This does not need to take a long time. The compassionate approach of the surgeon will go a long way in helping the patient to take the next steps in accessing other supports.
- Assess her safety (and the safety of any children) in her home. *“Do you feel safe returning home today?”*
- If she feels unsafe, and with her permission, initiate a safety strategy immediately through referral to social services or shelter as required.
- Provide care for her immediate injuries and orthopaedic-related issues.
- Take clear, legible, objective clinical notes, using her own words about abuse. Add diagrams or photographs, when appropriate. Should the patient be unwilling to talk about how she sustained her injuries or about the possibility of IPV, documentation and your impressions could be of benefit to the patient sometime in the future.
- Offer her a referral and contact information for counseling, shelter, social, and legal services. (See Appendix)

Intimate Partner Violence Education for Orthopaedic Surgeons

The COA encourages its members to educate themselves further about IPV. To support this, the COA has partnered with the Centre for Evidence-Based Orthopaedics at McMaster University to offer an IPV educational program (called EDUCATE), to fracture clinics across Canada free of cost. The EDUCATE program was developed by Sheila Sprague, Mohit Bhandari and the EDUCATE investigators with the purpose of providing orthopaedic surgeons and health care professionals working in fracture clinics with the knowledge and skills that will allow them to comfortably assist women who are victims of IPV. The EDUCATE program was designed using the best available evidence by experts in the field of orthopaedics, IPV, and education. It uses a multi-faceted approach to deliver training, including: an in-person presentation, videos, case sharing,

and interactive discussions. The EDUCATE program is designed to be both pragmatic and simple in its execution to ensure that it is feasible for busy health care providers to complete. From start to finish the entire program takes only 1 hour.

The EDUCATE program is delivered using a train-the-trainer model. To bring the EDUCATE program to a fracture clinic, one or more individuals from the fracture clinic volunteers to serve as a local IPV champion. The individuals will be provided with specialized training from the EDUCATE team to enable them to deliver the EDUCATE program to their fracture clinic team. The entire program, including training for Champions, is available free-of-charge through www.IPVEDucate.com.

In a pretest-posttest study of 140 health care providers who see patients in the fracture clinic, the EDUCATE program was found to significantly improve participants IPV-related knowledge, attitudes, beliefs, and self-reported behaviours. This suggests that health care providers who see patients in the fracture clinic feel better prepared to manage IPV after completing the EDUCATE program. The results of this study are published in open access format and are available through CMAJ Open (<http://cmajopen.ca/content/6/4/E628.figures-only>) or PubMed (<https://www.ncbi.nlm.nih.gov/pubmed/30563918>).

Simple Measures

Here are some suggested first steps that can facilitate helping victims of IPV:

- Participate in education to increase knowledge and comfort with identifying IPV and initiating assistance (e.g. the EDUCATE program).
- Initiate discussion among clinic health-care professionals about strategies for asking about abuse and providing assistance to patients who are experiencing IPV.
- Routinely ask all female patients about IPV.
- Arrange for privacy in the fracture clinic, where a partner or others can't overhear.
- Compile a list of local IPV services to which health-care professionals can refer patients.
- Contact hospital-based and community resources about anticipated referrals and possible partnerships.
- Place posters and pamphlets in the fracture clinic to signal disclosure is possible and help is available.

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