

Intimate Partner Violence

position statement by the Canadian Orthopaedic Association

Position Statement

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

Background

Intimate partner violence (IPV), spousal abuse, domestic violence and domestic assault are just some of the commonly used terms that describe a complex 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 intimate partner violence can occur in same-sex relationships. Women from all income and education levels, social classes, religions, racial groups and cultures experience intimate partner violence.

Canadian surveys of violence against women have calculated a prevalence rate of 8% of the female population, but due to under-reporting this figure must be considered very conservative. 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 choking, 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.

Patients are likely to present with ill-defined signs and symptoms, with multiple injuries, often sustained indoors in a domestic setting. 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, 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.

A 1997 study determined that only about one in four victims of intimate partner violence will disclose her domestic situation in the emergency room. Many women are not emotionally or physically ready to disclose when they are in an acute crisis. They are more focused on receiving care for their injuries. They may also be worried about the safety of their children or other family members. Moreover, contact may be too brief to form a bond of trust with the patient. Nevertheless, if possible, it is important to ask about IPV in the emergency ward, because asking the question informs the woman that a health-care setting is a good place to seek assistance when she is ready.

Disclosure depends on a number of factors: the patient's physical/emotional readiness, the type of clinical setting and a sense of trust in a particular care-giver. Follow-up visits to the fracture clinic (where research suggests as many as one in five women patients are IPV victims) or to the surgeon's office provide opportunities to develop a stronger surgeon/patient relationship. 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 ER to the doctor's office. Asking about IPV is as much about communicating the possibility of help as it is about screening for victims.

Roles and Responsibilities of Orthopaedic Surgeons

In Canada, physicians are not legally obligated to report abuse of adults to the police. Disclosure is a voluntary act, and, therefore, the decision to disclose or not disclose must be respected. However, 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 empathy 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 will involve social, legal and, possibly, 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 protection.

To be effective in helping victims of intimate partner violence, the health-care teams in the ER and fracture clinic need to feel they have the support of colleagues and hospital administrators. Ideally, these health-care providers would receive training in caring for patients who experience IPV, and they would have easy access to community-based social-service networks.

Surgeons and designated health-care professionals in the ER 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 IPV shelters
- toll-free help-lines for domestic violence
- print materials that reflect Canada's cultural diversity, if possible

Asking the Question

Surgeons and other health-care professionals interacting with women in emergency rooms, trauma clinics or office environments should conduct their assessment for intimate partner violence in a private setting, without the partner 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 for women being abused, 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 intimate partner violence. Under such circumstances, doing no more than providing immediate care may be the only recourse.

Suggested Steps After Disclosure

When a woman does disclose intimate partner violence 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 non-judgmental, empathic and supportive throughout the interaction.
- 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.
- If she requests, provide a referral and contact information for counseling, shelters and social and legal services. (See Appendix)
- A statement — such as, *“I’d rather risk offending you than miss the opportunity to provide you with some information or possible resources that could help you in the future.”* — can be very helpful in initiating a referral to social services and moving beyond the purely medical context.

Simple Measures

Here are some suggested first steps that can facilitate helping victims of intimate partner violence:

- Initiate discussion among clinic health-care professionals about strategies for screening patients who are experiencing IPV.
- During patient in-take, mark “IPV” on the chart to alert the surgeon of a possible victim.
- Arrange for privacy in the trauma clinic, where a partner can’t overhear.
- Contact hospital-based and community resources about anticipated referrals.
- Place posters and pamphlets in the trauma clinic to signal disclosure is possible.

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He currently holds a Canada Research Chair in Musculoskeletal Trauma and Surgical Outcomes and has published extensively on the topic of IPV in orthopaedic patients. Sonia Dosanjh is a Social Worker with over ten years of experience in helping women who have experienced IPV. Emil Schemitsch is the Division Head of Orthopaedic Surgery at St. Michael's Hospital in Toronto. He is a Professor at the University of Toronto and a Member of the Canadian Orthopaedic Association Executive Committee. Clare Freeman is the current Chair of the provincial Domestic Advisory Council for the Minister of Women's Issues and Children and Youth (2007-2009) and is the Executive Director of Interval House of Hamilton (an emergency abuse women shelter, counseling, outreach, and research services). David Mathews is the current Director of Therapy of the Domestic Abuse Project in Minneapolis. Dennis Jeanes is the Manager of Communications and Advocacy for the Canadian Orthopaedic Association.