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Editorial

Editorial: Protecting Patients from Intimate-partner Violence—What the Orthopaedic Surgeon Can Do

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If the numbers are to be believed—and there is little reason not to believe them—intimate-partner violence is not only terrible, it is also terribly common. Consider:

- The lifetime prevalence of severe, physical intimate-partner violence is more than 22% for women and—perhaps surprisingly to some—14% for men; many of these incidents will take place at the point of a knife or a gun [2].
- One in 7 homicides (and fully one-third of murders of women) are committed by an intimate partner [9].
- Sexual violence perpetrated by an intimate partner will harm 15.8% of women and 9.5% of men [2].
- The overwhelming majority of rapists—994 out of every 1000—will not serve one day in prison [8].
- An abuser's access to a firearm increases the risk of death during a domestic-violence incident more than sevenfold [3].

Yet despite findings from a high-quality, prospective, international study suggesting that one in six women who receive care in a fracture clinic have experienced intimate-partner violence within the last year [7]—and so in principle may still be in acute danger—only about one orthopaedic surgeon in every 25 screens patients for this threat [4]. Too many of us miss the chance to help some of the nearly 5 million women (and the several million men) whose intimate partners harm them every year [2].

For this reason, I am especially pleased to point readers to this month's Cochrane in *CORR*® column on intimate-partner violence by Ms. Madden and Dr. Bhandari, from the McMaster University's Evidence-Based Orthopaedics Group [5]. In it, they summarize a Cochrane review on the topic, which somewhat-fatalistically concluded that apart from increasing the number of patients identified as having experienced violence in the home, there was no evidence that routine screening for intimate-partner violence actually helped patients (such as through further referrals, reduced re-exposure to violence, or specific health metrics). The Cochrane analysts, therefore, deemed the evidence insufficient to justify screening patients for intimate-partner violence in healthcare settings.

I see it differently. Asking all patients—men and women—whether they recently have been abused can improve patient safety, so I believe orthopaedic surgeons, particularly in trauma clinics, should do it routinely. The Cochrane report unequivocally found that screening by healthcare providers increased the identification of patients who have experienced intimate-partner violence [6]. The report did not explore why increasing identification of patients failed to increase referrals for help, but it seems to me this is something a thoughtful

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surgeon can easily remedy. Importantly, the Cochrane report did not evaluate any trials in orthopaedic settings. Since musculoskeletal trauma is second in frequency only to head and neck injury in terms of the patterns of harm caused by domestic-violence incidents [1], we should assume we can achieve more than nonorthopaedic specialists achieved in this regard as reported in the Cochrane summary. We then should make every effort to do so. Finally, making such screening a routine part of patient intake, and addressing intimate-partner violence in sensitive, nonjudgmental ways when it comes up, can go a long way towards destigmatizing this important and dangerous health problem. In their Cochrane in *CORR*®, column this month [5], Ms. Madden and Dr. Bhandari, offer some thoughtful and practical suggestions for surgeons who want to get this right.

Read this month's Cochrane in *CORR*®, and make up your own mind. Then share your point of view in a letter to the editor at EIC@Clinorthop.org.

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