LETTER TO THE EDITOR

Intimate partner violence: an orthopaedic agenda

Christian Cotchobos,[1] Kudzai Chironga,[1,2] Salome Maswime,[1] Sithombo Maqungo[1,2]*

[1] Division of Global Surgery, University of Cape Town, Cape Town, South Africa
[2] Division of Orthopaedic Surgery, University of Cape Town, Cape Town, South Africa

**Corresponding author: sithombo@msn.com*

In 2019, South Africa made global headlines as thousands marched to parliament following the murder and rape of a 19-year-old university student. The population was taking a stand against gender-based violence (GBV). Femicide in South Africa is five times higher than the global average,[1] with intimate partner violence (IPV) being the primary contributor.[2] One in three women globally have experienced IPV in their lifetime, with the brunt borne by low-to-middle-income countries (LMICs).[2, 3] Despite this, the IPV challenge remains largely neglected in the LMIC setting, with a lack of meaningful interventions. Action needs to be taken.

IPV has devastating health-related and economic consequences. IPV survivors have been shown to utilise healthcare services at a higher rate than the general population.[4] This means that healthcare funds of resource-scarce countries are being used to treat potentially avoidable conditions. For example, IPV survivors are twice as likely to visit a gynaecologist, for conditions such as sexually transmitted infections, miscarriages and chronic pelvic pain.[5] IPV also affects the mental health of survivors. Depression, anxiety, insomnia and post-traumatic stress disorder all encumber this vulnerable group more than the general population. This limits their ability to contribute meaningfully to society.

We argue that IPV is also of significant surgical concern, particularly within a trauma setting. Survivors frequently present to emergency centres with traumatic brain injuries, stab and gunshot wounds, abdominal trauma and musculoskeletal injuries.[6] At Khayelitsha District Hospital in Cape Town, assault by a past or current intimate partner accounts for 26% of acute traumatic injury presentations among female youths.[7] Many of these patients require surgical interventions which further burden stretched surgical services. IPV survivors presenting with traumatic injury are in considerable danger – almost half of female homicide victims present to an emergency department in the two years prior to their murder.[8] IPV survivors are being missed and those who are identified do not receive adequate support.

Global health initiatives have traditionally focused on cost-effective primary care interventions, with surgery erroneously viewed as a tertiary level concern. However, there is a significant role to be played at all levels of care for the improvement of surgical services.[9] African patients are twice as likely to die from complications of surgery, compared to higher income countries. So why not focus efforts on preventing conditions that necessitate surgery in the first instance? Early detection and appropriate management of IPV patients could reduce the trauma burden and improve surgical outcomes. Healthcare professionals have a valuable role to play as the gateway to support services for IPV survivors.

Orthopaedic surgeons are particularly well placed to fulfil this role. After head and neck injuries, musculoskeletal injuries comprise the second most common manifestation of IPV.[11] This includes fractures, dislocations and sprains, which are commonly managed by orthopaedic practitioners. While there has been substantial IPV research in the fields of emergency medicine, family medicine, obstetrics and gynaecology, orthopaedic inquiry into the subject remains in its infancy globally. This attention is long overdue.

Orthopaedic wards and fracture clinics are ideal places to screen for IPV and provide a positive intervention.[4,11] Orthopaedic surgeons are often the first or second point of contact with the health system for IPV patients and trust can be fostered through serial follow-ups. A Canadian study found that 12% of women who did not disclose IPV at their initial orthopaedic visit, did so at follow-up visits within 12 months of the injury.[12] Physical injuries may also represent a tipping point in the cycle of violence which prompts survivors to seek help. Considering all of this, the American Academy of Orthopaedic Surgeons and the Canadian Orthopaedic Association have endorsed routine screening for IPV in fracture clinics.

However, despite these recommendations, orthopaedic surgeons are ill-equipped to deal with IPV patients. Research abroad indicates that practitioners feel uncomfortable discussing IPV with patients, rarely ask about IPV, and are unsure of support services available.[13-15] In some institutions in South Africa, IPV does not form part of the undergraduate medical curriculum nor is IPV training standard practice in the workplace. Consequently, junior doctors are likely to experience the same uncertainty as their overseas counterparts. Additionally, our doctors work in an overburdened healthcare system, where matters of social significance are often neglected in the face of high patient volume, lack of resources and time constraints.

South African public services are currently failing IPV survivors. In the wake of the 2019 GBV protests, the South African government pledged to fight GBV. However, little has been done to effectively combat this problem. While governmental organisations supporting IPV survivors do exist, the state is still largely reliant on private organisations. The result is a support landscape that is ever-changing and difficult to navigate. Not enough is being done to raise awareness about the services that do exist, with pervasive uncertainty among the medical profession and the general public. Services are also concentrated in urban hubs with poor reach into the country's rural areas, which are known to have higher rates of IPV.

We, as medical practitioners, are obligated to take responsibility for this plague of surgical morbidity. Orthopaedics, specifically, finds itself in a unique position, where meaningful interventions are possible, and change can be achieved. Further IPV inquiry in the orthopaedic setting is necessary if the problem is to be understood and interventions streamlined. Additionally, staff need to be trained and protocols developed to manage IPV patients. Finally, as healthcare providers, we need to advocate to the government for improved and ubiquitous IPV services to serve all our citizens.

References

1. African_Health_Organisation. Gender Based Violence Fact Sheet: South Africa2021 15 July 2023. Available from: https://aho.org/news/gender-based-violence-fact-sheet-south-africa/#:~:text=Femicide%20is%20five%20times%20higher,by%20the%20WHO%20in%202016
2. Devries KM, Mak JY, García-Moreno C, et al. Global health. The global prevalence of intimate partner violence against women. Science. 2013;340(6140):1527-28.
3. Organisation TWH. Global and regional estimates of violence against women. 2013.
4. Della Rocca GJ, Tornetta P, Schneider PS, Sprague S. Intimate partner violence and orthopaedics: AOA critical issues. J Bone Joint Surg Am. 2019;101(13):e62-e.
5. Daoud N, Kraun L, Sergienko R, et al. Patterns of healthcare services utilization associated with intimate partner violence (IPV): Effects of IPV screening and receiving information on support services in a cohort of perinatal women. PloS one. 2020;15(1):e0228088-e.
6. Sugg N. Intimate partner violence: prevalence, health consequences, and intervention. Med Clin North Am. 2015;99(3):629-49.
7. Leeper S, Lahri Sa, Myers J, et al. Assault-injured youth in the emergency centres of Khayelitsha, South Africa: Baseline characteristics & opportunities for intervention. Injury. 2019;50(12):2220-27.
8. Wadman MC, Muelleman RL. Domestic violence homicides: ED use before victimization. Am J Emerg Med. 1999;17(7):689-91.
9. Meara JG, Leather AJ, Hagander L, et al. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. Lancet (London, England). 2015;386(9993):569-624.
10. Biccard BM, Madiba TE, Kluyts H-L, et al. Perioperative patient outcomes in the African Surgical Outcomes Study: a 7-day prospective observational cohort study. Lancet. 2018;391(10130):1589-98.
11. Sprague S, Madden K, Dosanjh S, et al. Intimate partner violence and musculoskeletal injury: bridging the knowledge gap in orthopaedic fracture clinics. BMC Musculoskelet Disord. 2013;14(1):23-.
12. Madden K, Sprague S, Petrisor B, et al. Intimate partner violence during recovery from an orthopaedic injury: an exploratory, prospective, multicenter, observational cohort study. J Bone Joint Surg Am. 2022;104(6):512-22.
13. Downie S, Madden K, Bhandari M, Jariwala A. A prospective questionnaire-based study on staff awareness of intimate partner violence (IPV) in orthopaedic trauma patients. Surgeon. 2019;17(4):207-14.
14. Masarwa R, Ben Natan M, Yonai Y, et al. Awareness, knowledge, and screening for intimate partner violence among orthopedic surgeons in Israel. Violence against women. 2022;28(11):2877-88.
15. Bhandari M, Sprague S, Tornetta P, 3rd, et al. (Mis)perceptions about intimate partner violence in women presenting for orthopaedic care: a survey of Canadian orthopaedic surgeons. J Bone Joint Surg Am. 2008;90(7):1590-97.