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Beyond Identification of Patients Experiencing Intimate Partner Violence

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In this issue of American Family Physician, DiCola and Spaar give pragmatic guidance to family physicians on their role in responding to patients who are experiencing intimate partner violence (IPV).1 Their approach accords with the U.S. Preventive Services Task Force recommendation to screen all women for IPV. The United States is one of the few countries with a policy of screening for IPV. Guidelines from the United Kingdom’s National Institute for Health and Care Excellence2 and the World Health Organization3 recommend a low threshold for physicians to ask about IPV, but do not recommend routine screening. The evidence for screening in health care settings is contradictory, hence the discrepancy between the systematic review underpinning the U.S. Preventive Services Task Force guidelines4 and the Cochrane review on which the National Institute for Health and Care Excellence guidelines are based.5,6

I propose that we move beyond this debate, particularly in the context of family medicine, and focus instead on action that will protect the safety of patients experiencing IPV. My rationale for this proposal is twofold.

First, screening programs are not all that different from targeted inquiry approaches. We know that screening programs increase disclosure of IPV in health care settings. We also know that training family physicians to ask about IPV, particularly when there is a referral pathway to further support the patient, also increases disclosure.7 There are no head-to-head trials of screening vs. clinical inquiry (or active case finding), so we do not know which is more effective. Given that even in trials screening by physicians is only partial, in reality, the operational difference in the family medicine clinic between an IPV screening program and a targeted clinical inquiry program is likely to be minimal. Physicians do not implement screening not only because of time constraints, lack of training, and discomfort with asking about abuse, which would affect any IPV identification method, but also because they are skeptical about the evidence base.8

Second, the IPV screening vs. active case finding debate is a distraction for researchers, systematic reviewers, and physicians, because it focuses attention and resources on what is only the first step in an effective (and safe) response to survivors of IPV in clinical settings. The ensuing steps after a patient has disclosed abuse to a physician (or physician’s assistant or nurse) are as important as eliciting disclosure, regardless of the identification method. These steps include the physician giving an appropriate and validating response, checking for safety, offering referral to IPV support agencies, facilitating uptake of that referral (i.e., more than just offering a list of agencies), and offering ongoing physician contact.

What is the thread that ties effective identification of IPV survivors to effective management? Training. Given the absence or low profile of undergraduate or postgraduate medical training on IPV, how can we expect physicians and other clinicians to engage with the issue? They often do not understand the epidemiology of IPV, its coercive reality, the entrapment of survivors, and the severe safety risks, which may inhibit disclosure of the abuse or use of support services. Asking about IPV in a family medicine setting, via a screening tool or in the course of taking a clinical history, requires training and practice. A systematic review of nine trials of IPV training interventions for physicians showed that only multifaceted physician training that combined education with system support interventions changed physician behavior related to IPV. System support activities included displaying posters and brochures about violence in waiting areas, and providing prompts to physicians, checklists in medical records for IPV diagnosis.
Efficacy of Fluzone High-Dose in Adults 65 Years of Age and Older

Study 2 (NCT01427309) was a multi-center, double-blind post-licensure efficacy trial conducted in the US and Canada in adults 65 years of age and older randomized (1:1) to receive either Fluzone High-Dose or Fluzone. The study was conducted over two influenza seasons (2011-2012 and 2012-2013); 53% of participants enrolled in the first year of the study were re-enrolled and re-randomized in the second year. The per-protocol analysis set for efficacy assessments included 15,892 Fluzone High-Dose recipients and 15,911 Fluzone recipients. The majority (67%) of participants in the per-protocol analysis set for efficacy had one or more high-risk chronic comorbid conditions.

In the per-protocol analysis set, females accounted for 57.2% of participants in the Fluzone High-Dose group and 58.1% of participants in the Fluzone group. In both groups, the median age was 72.2 years (range 65 through 100 years). Overall, most participants in the study were White (95%); approximately 4% of study participants were Black, and approximately 6% reported Hispanic ethnicity.

The primary endpoint of the study was the occurrence of laboratory-confirmed influenza (as determined by culture or polymerase chain reaction) caused by any influenza viral type/subtype in association with influenza-like illness (ILI), defined as the occurrence of at least one of the following respiratory symptoms: sore throat, cough, sputum production, wheezing, or difficulty breathing; concurrent with at least one of the following systemic signs or symptoms: temperature >99.0°F, chills, tiredness, headaches or myalgia.

ADVERSE REACTIONS

Vaccination with Fluzone High-Dose may not protect all recipients.

The majority of these participants were randomized to Fluzone. Females accounted for 51.3% of participants in the Fluzone High-Dose group and 51.7% of participants in the Fluzone group. In both groups, the median age was 72.3 years (range 65 through 100 years). Overall, most participants in the study were White (95%); approximately 4% of study participants were Black, and approximately 6% reported Hispanic ethnicity.

The primary endpoint of the study was the occurrence of laboratory-confirmed influenza (as determined by culture or polymerase chain reaction) caused by any influenza viral type/subtype in association with influenza-like illness (ILI), defined as the occurrence of at least one of the following respiratory symptoms: sore throat, cough, sputum production, wheezing, or difficulty breathing; concurrent with at least one of the following systemic signs or symptoms: temperature >99.0°F, chills, tiredness, headaches or myalgia. Participants were monitored for the occurrence of a respiratory illness by both active and passive surveillance, starting 2 weeks post-vaccination for approximately 7 months. After an episode of respiratory illness, nasopharyngeal swab samples were collected for analysis; attack rates and vaccine efficacy were calculated (see Table 3).

<table>
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<th>Strain</th>
<th>Study 1 (NCT00391053)</th>
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**REFERENCES**