PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Is a clinician's personal history of domestic violence associated with their clinical care of patients? A cross-sectional study.
AUTHORS	McLindon, Elizabeth; Humphreys, Cathy; Hegarty, Kelsey

VERSION 1 - REVIEW

REVIEWER	Sajaratulnisah Othman University of Malaya Malaysia
REVIEW RETURNED	15-Feb-2019

GENERAL COMMENTS	This is an important study as it provides additional information on domestic and family violence intervention and health care providers. The originality of this study is the first study to examine this issue in Australia. The title reflects the manuscript content and justification for this study is clear. Overall, it is easy to follow the description of this study. The measures used to identify DV is given. Similarly, for the measure of FV experience. For further clarity, it would be good to specify in what combination of positive measure for DV and FV that one was considered as having experience of DFV. In terms of training, the participants were categorized as having <1 day or 1+ day of DFV training, giving an indication that all participants have undergone DFV training. Is this true? Otherwise, how did this study address those who have not received any DFV training? The results section provides answers to the study objectives. However, Table 3 provides additional information that is not within the study objectives. It is about the overall effect of training on the practice of DFV regardless of participants' background exposure of DFV. The statement on page 7 line 18 "… no more likely to find it upsetting to talk about DFV.." is quite confusing and need to be rephrased. It is unclear the reason for emphasizing this finding since it is not a significant finding. Furthermore, there is also no elaboration in the discussion section regarding this matter. The statement on page 8 line 41-44 is unclear in its meaning and whether the information is shown in any of the tables.

	There are discrepancies between the figures stated at page 7 line 25 & 26 (aOR for identifying survivor patients and aOR for safety planning) and in Table 3. This needs to be addressed. The discussion is relevant and good. There is a concern with a low response rate, but this is addressed appropriately in the discussion.

REVIEWER	Natalia Lewis University of Bristol, UK
REVIEW RETURNED	06-May-2019

GENERAL COMMENTS	Dear authors congratulations on a well written manuscript. It reports well-designed and delivered cross -sectional study with a convenience sample of hospital-based health care professionals. The main finding is that professionals who have experienced intimate partner violence (IPV) or family violence (FV) are more likely to attend training on these topics and feel more prepared to respond to patients with similar experiences. The manuscript requires minor edits to the IPV/DV/FV terminology and some additions to the reporting. Background. I found your definition of domestic violence (DV) vs family violence (FV) confusing. On p. 2, line 34, you cite the WHO definition of intimate partner violence (IPV) but call it “domestic violence”. The cited WHO report clearly states: “family and intimate partner violence – that is, violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home.” (p. 24 of the Report). Another WHO seminal paper (https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1) explains that “The term ‘domestic violence’ is used in many countries to refer to partner violence but the term can also encompass child or elder abuse, or abuse by any member of a household.” I suggest to follow the WHO report and call the phenomenon you measured either DV or FV and explain at the beginning that you were interested in both IPV (captured by the CAS) and violence by a non-intimate family member (captured by two questions about violence from “other” family members and childhood exposure to IPV between parents). Aim, design and setting. You hypothesise that health care professionals with experience of DV are more likely to be better prepared to identify and respond to patients with similar experiences (p. 3, line 58). Could you please justify your hypothesis. One can argue that those professionals who have been traumatised by DV are more likely to avoid working with DV patients to prevent re-traumatisation. Aim, design and setting. Could you please justify the choice of the “one Australian tertiary maternity hospital” (p. 4, line 15). Data collection and measures. In Table 1 (p. 5), could you please indicate which measures were standardised validated questionnaires and which were bespoke questionnaires developed for this study. Participant characteristics. When reporting a 45% response rate (p. 7, line 25), can you give details of the response rates by professional groups. I expect that nursing/allied staff showed higher response rates than doctors.

	Strengths & limitations. You acknowledge “the possibility that non-respondents may have differed from respondents in a way that affected our conclusions.” (p. 11, line 46) Can you explain in more detail in what direction (underestimated/overestimated associations) this could result. Discussion. Can you bring to the discussion the definition of a trauma-informed care and cite seminal papers on this approach.

VERSION 1 – AUTHOR RESPONSE

Reviewer recommendation	Author’s response and changes made
Reviewer 1 & 2 comment	
The terminology in the manuscript was not clear	We apologise that the terminology was not clear enough. We have heeded Natalia’s advice, and within the manuscript, we now use the term DV. Changes are made throughout, most notably in the ‘Background’ (page 2) and ‘Data collection and measures’ (page 4).
Reviewer 1 comments	
Need clarification about participants who have not received any DFV training	Participants with no DV training were included in the ‘<8 hours’ group and we have now specified this as per note c in Box 1
Table 3 provides additional information that is not within the study objectives.	We now state in ‘Aim, design and setting’ (pg 3) that while not an initial focus of the study, the effect of training on clinical practice emerged as an interesting finding during the data analysis and was included in the results.
The statement on page 7 line 18 “… no more likely to find it upsetting to talk about DFV..” is quite confusing and need to be rephrased. It is unclear the reason for emphasizing this finding since it is not a significant finding. Furthermore, there is also no elaboration in the discussion section regarding this matter.	This finding was important and mentioned here because it was not significant. We think it is interesting to have found that survivor health professionals (HPs) do not find it more upsetting than HPs without a history of DV to talk about DV with their patients. If the finding had been statistically significant it would suggest that survivor HPs do find it upsetting to talk with patients about DV, which would in turn, have important implications for DV screening common in healthcare. Thank you for letting us know it was not clear. We have rephrased the sentence in the results for clarity. It now reads: Survivor health professionals were no more likely than others to find it upsetting to talk about DV with their patients (page 7).

The statement on page 8 line 41-44 is unclear in its meaning and whether the information is shown in any of the tables.	Thank you for pointing this out. We have moved and slightly expanded this sentence, specifying that it is also in Table 3. It now reads: “The analysis also suggested that allied health professional participants (i.e. social workers) were more likely to have had 1+ days of DV training and to have safety planned and referred survivor patients than other professional groups (Table 3)” (page 7).
There are discrepancies between the figures stated at page 7 line 25 & 26 (aOR for identifying survivor patients and aOR for safety planning) and in Table 3. This needs to be addressed.	Thank you for alerting us. These were rounding discrepancies and have been amended where needed (page 7 and page 9)
Reviewer 2 comments	
You hypothesise that health care professionals with experience of DV are more likely to be better prepared to identify and respond to patients with similar experiences (p. 3, line 58). Could you please justify your hypothesis. One can argue that those professionals who have been traumatised by DV are more likely to avoid working with DV patients to prevent re-traumatisation.	We certainly take your point. As we say in the Background, the previous evidence is mixed and that was a motivator for our study. We had to pick a side and because of our anecdotal experience working alongside survivors and knowing them to be hardworking, often going the extra mile with patients, we chose to hypothesise that they would be more likely to be prepared to identify and respond.
Aim, design and setting. Could you please justify the choice of the “one Australian tertiary maternity hospital” (p. 4, line 15).	We chose this hospital because it was a large maternity site that one author had connections with.
Data collection and measures. In Table 1 (p. 5), could you please indicate which measures were standardised validated questionnaires and which were bespoke questionnaires developed for this study.	We have now added this information to Box 1 (page 5).
Participant characteristics. When reporting a 45% response rate (p. 7, line 25), can you give details of the response rates by professional groups. I expect that nursing/allied staff showed higher response rates than doctors.	We did not put this information into this paper because an overview of it is in Table 1 of McLindon, E., et al. (2018). ""It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals." BMC Womens Health 18. In short, the response rate for each professional group was: Nurses & Midwives: 53.3%

	Medical: 46.0% Allied health: 49.2% Other clinical (incl. medical support and those who did not answer 'profession' question): 17.8% The response rate for the medical staff were not greatly different to nursing and allied health.
Strengths & limitations. You acknowledge "the possibility that non-respondents may have differed from respondents in a way that affected our conclusions." (p. 11, line 46) Can you explain in more detail in what direction (underestimated/overestimated associations) this could result.	On page 10, we say, "It is possible that DV survivors were more motivated to participate in the project than other people [20], and we acknowledge the possibility that non-respondents may have differed from respondents in a way that affected our conclusions." Having suggested that DV survivors may have been overrepresented in the sample, we cannot really say beyond that whether that may have contributed to an over/underestimate of associations. We would only be guessing.
Discussion. Can you bring to the discussion the definition of a trauma-informed care and cite seminal papers on this approach.	Great idea. We have done this – see page 12

VERSION 2 – REVIEW

REVIEWER	Natalia Lewis University of Bristol, Bristol Medical School, Population Health Sciences
REVIEW RETURNED	10-Jun-2019

GENERAL COMMENTS	Thank you for addressing all of my comments and suggestions.