Intimate partner violence education in Australian medical schools: has anything changed?

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Abstract

Objectives: To describe current intimate partner violence (IPV) education delivery to Australian medical students, and the barriers influencing this delivery, including any changes in the quantity and nature of IPV education delivery since 2010.

Methods: A cross-sectional analysis of Australian medical schools providing primary medical degrees was conducted by identifying one staff member, from each of the disciplines of general practice, obstetrics and gynaecology, paediatrics, and where necessary, medical education, to complete an online survey.

Results: Sixteen of the 17 medical schools provided IPV education, typically within the general practice or obstetrics and gynaecology curriculum. The median contact hour range was 3–6 hours. Key barriers included time constraints and resource shortages. The overall response rate was 89.5%.

Conclusion: Most Australian medical students receive limited IPV education and there is substantial variability in the depth and content of education. The proportion of medical schools providing education and the number of contact hours has only slightly increased.

Implications for public health: Effective identification and management of IPV by healthcare providers can significantly improve health outcomes for victims and training in IPV may improve attitudes, knowledge and clinical skills. The need to provide more consistent and comprehensive IPV training for future doctors remains, and it is feasible to include integrated IPV education programs within a crowded medical curriculum.

Key words: domestic violence, intimate partner violence, medical education, pre-vocational medical education, family violence

Intimate partner violence (IPV) is a highly prevalent, global problem with far-reaching implications for health and wellbeing.[1] IPV is defined by the World Health Organization as "behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours".[1] In Australia, one in six women and one in 16 men report having experienced physical or sexual violence by a current or former partner.[2,3] However, the main burden of IPV is on women and their children, with one woman killed every week and one man killed every month by a partner.[2,4] IPV is thus a leading contributor to ill health and premature mortality among women of childbearing age.[1,2,5] Women who experience IPV are more likely to suffer depression, anxiety, alcohol and substance abuse disorders, and IPV is also frequently associated with chronic pain, gynaecological issues and other general health issues.[6-11]

For people experiencing IPV, a doctor or healthcare provider is often the first and only professional contact.[1,12-14] For this reason, clinical practice guidelines recommend that identification and management of IPV be considered standard patient care.[1,15-17] However, this is not reflected in clinical behaviour, with a hesitancy among doctors to inquire about IPV and patients often not disclosing abuse without direct questioning.[17-20] Why the disparity between recommendations and practice? Insufficient IPV education and pre-vocational training may play a role.[21]

Existing literature has shown that – when delivered at all – IPV education is often inconsistent, structureless and limited by time constraints.[21-25] The VOICE study,[24] a similar Australian study conducted in 2010, demonstrated that 80% of Australian medical schools delivered some IPV education with the median number of contact hours dedicated to IPV being two across the entire degree. The depth and quality of this education were highly variable.[24] Yet, future doctors are extremely likely to encounter IPV victims in their clinical practice, and training in IPV identification and management may improve attitudes, knowledge and clinical performance.[21,26,27] For example, a recent study of gender-based violence (GBV) education tools for pre-vocational healthcare students suggested that attitudes towards IPV, and – to a lesser extent – knowledge and skills, were more positively changed by longer, more interactive courses.[21] Note: we understand that some people experiencing IPV prefer the word 'survivor' while others prefer victim or survivor; we have just used the terminology victim in this study.

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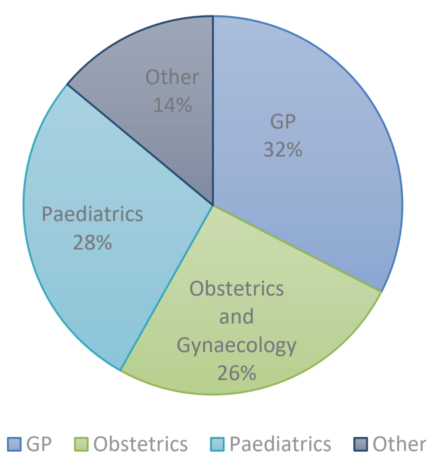
Part of the systematic approach to ending IPV involves improving education and training for future and current health professionals.[26] This study, therefore, aims to describe current IPV education delivery to Australian medical students and the barriers influencing this delivery. Given the recent shift in public awareness,[28,29] this study also aims to describe any change since the VOICE study[24] in the quantity and nature of IPV education delivery to Australian medical students. The VOICE study[24] has been used as a key comparator as it is the only benchmark study describing IPV education for future doctors.

Methods

A systematic search of all Australian universities revealed 21 medical schools offering primary medical degrees in Australia. Two universities were excluded as their new, graduate-entry medical curricula were yet to be finalised. For the remaining 19 medical programs, one staff member from each of the disciplines of general practice, obstetrics and gynaecology, paediatrics and – if necessary – medical education with the greatest insight into the relevant curriculum was identified by contacting discipline heads and medical education contact lists. Staff members were sent the online survey link via email; prior to commencing the survey, participants read a statement outlining the study purpose, potential outcomes and other relevant information to enable informed consent. Participants then chose to complete the survey and data were collected between 2018 and 2019. The study was approved by the Melbourne Human Research Ethics Committee (1851187).

The online 10-minute survey (using Survey Monkey) was based on that used in the VOICE study with the same questions and response categories to enable comparison with some additional questions added to gain new insight. The survey asked participants about the medical school and discipline where they worked. They specified whether IPV-specific content was delivered in the medical degree, and if so, within which discipline. If IPV education took place at their medical school, participants were asked more specifically about the quantity of teaching (hours), modes of delivery, topics covered, at what stage(s) of training education it occurred, whether it was compulsory, who delivered the content, and if they felt the current quantity of IPV education and the teaching methods were adequate. Those disciplines that did not deliver any IPV education were asked about the barriers to incorporating IPV education and whether it would be introduced in the future. All participants were asked to identify and discuss any factors that impacted their medical school's ability to deliver IPV education, and whether they thought it should form part of the curriculum using comments boxes to collect qualitative responses.

Figure 1: Respondents by Discipline.



Note:
Figure 1. What academic department do you work in? Please note that 'Other' included medical education, social studies (law, ethics, professionalism), public health, community health, and psychiatry.

When multiple responses were received from each medical school, results were collated additively to achieve one overall response representative for each school. Descriptive statistics were generated using Excel for demographic data and quantitative responses to closed questions. Comments from open-ended responses were used to illustrate quantitative findings where appropriate.

Results

Seventeen of nineteen eligible medical schools participated in the survey (89.5%). One medical school could not be reached, and one declined to participate. In total, 43 survey responses were received and the number of responses per university varied from a minimum of one response to a maximum of four responses. The number of responses for each university and clinical discipline of responders is presented in Table 1. There was a diverse range of individuals who completed the survey including professors, associate professors, department heads, lecturers, and clinicians. Responders represented general practice (32%), obstetrics and gynaecology (26%), paediatrics (28%) and other disciplines (14%), see Figure 1. Additionally, four responses were from staff in the faculty of medical education, two from law, ethics and professionalism, two from public health, one from community health and one from psychiatry.

IPV education, delivery, and content

Of the seventeen medical programs from which responses were obtained, sixteen provided some form of IPV education (94.1%). A majority of medical schools reported that at least some of this education was compulsory (n=14), whereas two universities stated education was elective in nature. Among the medical schools that provided IPV education, one delivered it in the early years of the course, seven in the middle years and six in the final years, and two schools provided education across more than one stage of the degree. Some respondents referred to additional teaching that may take place opportunistically during the clinical years.

When provided, IPV education was usually included in the general practice (n=10), obstetrics and gynaecology (n=10) and paediatrics (n=5) curriculums. Many medical schools, however, reported that IPV education took place across multiple disciplines. Other curriculum areas included social foundations of medicine, sexual health, psychiatry, professionalism, public health, society and health, and communication skills. importantly, respondents from paediatrics reported content generally focused on child abuse and child protection issues in the context of family violence rather than teaching specifically about the identification and management of IPV. Where IPV content was included, three to six contact hours allocated to teaching IPV and related content was most common (n=8). The most comprehensive IPV education programs allocated more than 10 hours and content tended to be integrated across the duration of the course (n=4). Table 2 outlines the number of contact hours allocated to IPV education.

The method of delivery of IPV education varied across medical schools. Eleven medical schools incorporated IPV content into a problem-based learning tutorial or small group session. Fifteen schools presented IPV-related content in either a dedicated lecture or as part of a lecture, five as online modules and four as workshops, and seven schools referred to experiential learning during clinical placements. Multiple medical

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schools used a combination of formats to deliver IPV education. Most medical schools utilised clinicians including general practitioners, obstetricians, psychiatrists, and academics for whom IPV was an interest area to deliver content (n=16). Four schools engaged external members of the community to provide education, including hospital social work, community workers and representatives from a sexual assault resource centre. At one medical school, content was delivered in part by law enforcement representatives.

Table 3 summarises the specific topics covered by education programs. A majority of medical programs provided a general overview of IPV against women (n=14) and discussed interventions (n=15), focusing on identifying and responding to domestic violence. Most schools included risk factors and correlates that may lead to IPV, epidemiology, child protection issues, characteristics of victims and perpetrators, issues relating to indigenous communities and the health consequences. Few medical programs used a model, framework, or theory to underpin IPV education (n=6). Topics covered less frequently included gender issues, common couple violence, same-sex relationships and issues specific to multicultural communities.

Table 1: Number and discipline of respondents representing each university.

University	Discipline of respondents				
	General Practice	Obstetrics and Gynaecology	Paediatrics	Other	Total responses
1	1	1	1	0	3
2	1	1	0	0	2
3	1	1	0	0	2
4	2	0	2	0	4
5	2	0	1	0	3
6	0	1	0	1	2
7	0	1	0	0	1
8	1	1	1	1	4
9	1	1	1	0	3
10	1	0	2	1	4
11	0	0	0	2	2
12	1	1	1	1	4
13	1	0	1	0	2
14	1	1	1	0	3
15	0	1	0	0	1
16	1	1	0	0	2
17	0	0	1	0	1
Total	14	11	12	6	43

Barriers to IPV education

The key barriers to providing IPV education are summarised in Table 4. Fourteen of the total of seventeen responding medical schools reported time constraints to be a barrier to the delivery of IPV education, especially in the context of an already overloaded curriculum and competing demands among departments. As two participants stated:

> *I think we have many willing experts, but we have significant issues with delivering a balanced ... not overloaded curriculum.* (University 8)

> *One student asked why such an important public health issue was only given one hour in the whole curriculum. I was unable to answer her.* (University 10)

Several respondents from paediatrics reported a limited ability to include any IPV content in their course despite its impact on children, as they often have insufficient time to include all relevant paediatric-specific learning objectives. Interestingly, a respondent from University 9 stated that "domestic violence between adults is not taught as it does not relate directly to paediatrics".

Additionally, lack of access to expert teachers (n=11), resources (n=9) and funding (n=5) were identified as barriers to IPV education delivery. Further, half of the medical schools reported department commitment to IPV teaching to be a barrier with some discipline leads unprepared to include IPV education. The responses below further highlight these key barriers to the provision of IPV education. Two participants reported:

> *The topic, although very important, seems to be in 'no man's land' rather than a structured part of a given curriculum.* (University 3)

> *It [IPV education] is going into GP [curriculum] as the current O&G professor is not interested in keeping it in his course.* (University 10)

The opportunity for curriculum renewal and revision was reported to impact IPV education delivery (n=8), with many medical programs reporting that their school had plans to change IPV education delivery in the future by providing additional teaching resources or increasing contact hours, or through ongoing curriculum evaluation and updates (n=14). One medical school reported that IPV education would be included in the form of both lectures and assessment tasks in 2019 following a broader curriculum revision.

Table 2: IPV contact hours (n=17 medical schools).

Hours	n (%)
0	1 (5.9 %)
1-2	2 (11.8 %)
3-6	8 (47.1 %)
7-10	1 (5.9 %)
>10	4 (23.5 %)

Note:

Table 2. Please indicate the number of contact hours allocated to domestic or intimate partner violence education. Respondents were asked to select the range of IPV contact hours that applied to their discipline. Hours were added together where content was taught across multiple disciplines at the one medical school. Data was then analysed by medical school. IPV = Intimate partner violence.

Conversely, one medical school reported no barriers to IPV teaching, as it was very well supported by their university, and their teaching was aided by external specialists in the field.

This medical school also had IPV education integrated throughout the degree. Three other medical schools reported a need to integrate IPV across the duration of the degree; for example, by including IPV education in each year of the course or by including IPV themes in problem-based learning case discussions. Three participants illustrated this:

> *Domestic violence materials now need to be written into a PBL case so that students get additional opportunities to discuss various issues touched on in the lecture.* (University 6)

> *Curriculum leads plan to develop a clearer and more coherent curriculum addressing this across all four years.* (University 17)

> *The quantity [of education] is probably enough but we need to embed it vertically throughout the course, rather than [have it] concentrated in Year 3.* (University 8)

Additionally, four medical schools reported the quantity of IPV teaching to comprise

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more than 10 hours (University 2, 3, 9 and 16). These same medical programs also integrated IPV education across at least three years of the degree and used at least three different teaching methods to deliver the relevant curriculum.

Perceived efficacy of current IPV education

Several respondents reported that the current quantity of IPV education at their university was not quite enough (n=12), whereas six felt current levels were inadequate, and eight respondents reported the quantity to be about right given competing curriculum demands and time constraints (See Table 5).

Discussion

This study demonstrated that the vast majority (95%) of Australian medical schools provide IPV education in some form, an increase from 80% in the last decade.[24] As with the results of the VOICE study,[24] there was significant variability in the depth and content of education delivered across the medical programs. Overall, however, the number of contact hours allocated to IPV education has increased slightly with most medical schools now providing three to six hours, in comparison to a median of two hours being provided 10 years ago.[24] Only four medical schools employed a comprehensive, integrated and multi-staged education program comprising more than 10 contact hours. Content was often taught across two or three disciplines, and material was delivered most often in a simple lecture format or as part of a small group session. Several medical programs reported relying on exposure during clinical placements covering IPV and related topics, indicating that many schools are still taking an ad hoc approach. While this study suggests that IPV education in medical schools has improved marginally, there are likely many students who will still graduate without adequate training in IPV identification and management.[21] This variability in quality and content in Australian medical courses is consistent with existing international literature.[22-25,30]

IPV contributes more to the burden of disease for women of childbearing age than any other risk factor, including tobacco use, high cholesterol, or illicit drug use.[10,31] Exposure to IPV is also a major adverse child event for disease in later life.[32] Thus, it might be expected that IPV would be given as much focus in medical curricula as other risk factors of similar prevalence and impact. Yet this is not the case; IPV education remains fragmented, and its necessity poorly understood.[10,31] Again and again, respondents report time constraints, competing curriculum demands, inadequate resources, and perhaps a failure by some to recognise the importance of teaching about IPV to be key barriers that have seen this content consistently under-prioritised by medical schools.[22-25,33] These barriers have remained essentially unchanged over time when compared to previous Australian and international research on this topic.[24,25] The next step for medical schools is to address these barriers through improved and more coordinated leadership at a university level to ensure all future doctors are trained in this major public health issue. There is a need for greater commitment to curriculum revision, as evidence demonstrates that integrated education taught at multiple points and in greater quantities can improve healthcare student's attitudes, and to a lesser degree, knowledge and skills in addressing IPV.[21,27,34,35]

Since previous data on this topic have been published, there has been a significant

Table 3: Intimate Partner Violence Topics Covered (n = 17 medical schools).

Topic areas	n	(%)
General overview of domestic violence against women	14	(82.4%)
Specific knowledge to aid learners in responding to domestic violence (e.g. interventions)	15	(88.2%)
Domestic violence risk factors or correlates	14	(82.4%)
Mental health consequences	14	(82.4%)
Epidemiology	12	(70.6%)
Specific knowledge to aid learners in identifying domestic violence	14	(82.4%)
Physical health consequences	13	(76.5%)
Child protection	14	(82.4%)
Discuss issues specific to indigenous communities	12	(70.6%)
Provide case studies	12	(70.6%)
Specific details about characteristics of domestic violence victims and perpetrators	10	(58.8%)
Female genital mutilation (FGM)	9	(52.9%)
Present information about local community resources	9	(52.9%)
Discuss domestic violence by women against men	7	(41.2%)
Discuss common couple violence (e.g. violence by both partners against one another)	7	(41.2%)
Discuss issues specific to multicultural communities	7	(41.2%)
Discuss domestic violence in same sex relationships	7	(41.2%)
Utilise a model, framework or theory to guide education on domestic violence	6	(35.3%)
Gender issues	4	(23.5%)

Notes

Table 3. What, if any, of these topics or approaches are included in your intimate partner violence education?

Participants were asked to select relevant topics taught at their medical school from a list presented in the questionnaire. Responses were added together where content was taught across multiple disciplines at the one medical school. Data was then analysed by medical school.

Table 4: Barriers to IPV education (n=17 medical schools).

Barrier	n (%)
Adequate amount of time to include domestic violence content in curriculum	14 (82.4%)
Availability and access to experts who teach this content	11 (64.7%)
Access to resources for delivery of this content	9 (52.9%)
Faculty/department commitment to domestic violence education	9 (52.9%)
Opportunity for curriculum renewal/revision	8 (47.1%)
Funding allocation for domestic violence education	5 (29.4%)
Receptiveness of education recipients to this content	2 (11.8%)

Note:

Table 4. Which of the following factors might impact your ability to deliver intimate partner and domestic violence education? Respondents were asked to select relevant barriers impacting IPV education at their medical school from a list presented in the questionnaire. Responses were added together where content was taught across multiple disciplines at the one medical school. Data was then analysed by medical school.

Table 5: Perceived efficacy of current IPV education (n = 28) .

Rating scale	n (%)
Inadequate	6 (21.4%)
Not quite enough	12 (42.9%)
About right	8 (28.5%)
A little too much	0 (0.00%)
Far too much	0 (0.00%)
Unsure	2 (7.14%)

Note:

Table 5. What do you think about the quantity of IPV teaching currently provided at your medical school? Respondents were asked to select a response from options listed in the survey. Data analysed by respondent, total number of respondents to this survey question = 28.

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shift in public awareness of domestic and family violence, along with unprecedented funding towards programs and interventions designed to combat the issue.[28,29] While advocacy work is far from finished, the understanding of IPV as an important and prevalent health issue for women and their children may have improved greatly. It is possible that this shift and the broader commitment to address this issue from government, law enforcement agencies and the health sector has in turn brought about increased awareness among medical educators. The information provided by academic staff in this study has provided valuable insight into how the medical curriculum has changed, albeit minimally, in response to improved cognisance around IPV. Additionally, the pre-vocational period, while important, is not the only time during which medical trainees may have the opportunity to develop clinical skills in IPV identification and management. It should thus be noted that junior doctors, especially those who pursue careers in general practice and women's health, may also receive IPV training once they commence clinical practice.[15,36,37]

Strengths of this study include the high response rate achieved, indicating that our sample is likely representative. The choice to survey multiple respondents from each university likely led to an accurate representation of education delivery. This survey also used both quantitative and qualitative data to describe current IPV education across Australian medical curricula. Surveying medical students, however, was beyond the scope of this study. Thus, measuring student experience of IPV education and assessing attitudes towards IPV, as well as knowledge and skills in managing IPV, was not feasible. Another limitation is the heterogeneity of the participants. Identifying the most suitable respondents at each university proved challenging, with many unsure of whether additional IPV education took place in disciplines other than their own. We chose to survey multiple respondents from each medical program; in some cases, there were conflicting responses from respondents representing the same university, which made data analysis difficult.

The influence of a 'local champion', a university staff member who advocates for IPV education at their medical school, may indeed correlate with the provision of IPV education in medical schools, as has been reflected in previous studies relating to Australian and UK contexts.[24,25] As was the case in these studies, the local champion tended to answer more positively and in more detail, as they were likely responsible for driving the curriculum reform in their medical programs.[24,25] Our data may thus be positively skewed towards the recognition of the need for more and improved IPV teaching. While it is encouraging that many universities have an advocate, it also may indicate that IPV is still not broadly viewed as a legitimate medical issue that requires a comprehensive, integrated approach. While we achieved a high response rate, it is also possible that potential respondents who were conscious of the lack of IPV education provided by their medical school chose not to participate.

While IPV education was shown to be more frequent, the inconsistency across medical programs and the lack of data about the efficacy of current teaching means that we remain unsure of whether future doctors will be able to effectively identify and manage patients suffering this kind of violence. Future research could focus on how medical students perceive IPV education, their perceived readiness to identify and manage IPV, and the relationship between different methods of education and clinical aptitude in later practice.

Conclusion

In conclusion, teaching of IPV has slightly improved over the last decade.[24] Medical students today have more contact hours dedicated to this important health concern, and more medical programs have taken an integrated approach. This is encouraging as it demonstrates that IPV can be addressed despite the competing curriculum demands and time constraints commonly afflicting medical programs. There is still no cause for complacency, however, as – despite improvement – education largely remains fragmented rather than integrated throughout the medical curriculum. Few medical programs are being well supported to teach students about IPV and some still have no dedicated IPV education.

International guidelines, the Royal Australian College of General Practitioners (RACGP), and the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) recommend that IPV is taught to doctors in training, and it is expected that the healthcare sector cares actively and consistently for patients experiencing IPV.[15,38,39] This study highlights a clear gap between these expectations and the reality of education and preparation of future doctors. Current teaching levels are inadequate when we consider the vastness of IPV as a health issue. Consistent and comprehensive training must be provided. Medical educators must prioritise IPV as being equal to that of other prevalent health risks if the next generation of doctors is to be able to appropriately recognise and care for patients suffering IPV.

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