Domestic abuse is defined as ‘controlling, coercive, threatening, degrading and violent behaviour’ by an intimate partner, family member or carer.1 Globally, one in three women experience domestic abuse in their lifetime.2 Since the onset of the COVID-19 pandemic, the rate of domestic abuse reporting has risen dramatically in the United Kingdom. The United Kingdom-based charity, Refuge reported an average 66% increase in the weekly number of calls to the National Domestic Abuse Helpline, and a 950% increase in traffic to its website.2 Early 2020 data warned of a similar trend in countries like Australia, Brazil and Italy,3 where individual complaints of domestic violence in France and the United States rose by 35–36%, while in China the number of incidents was reported to increase threefold.3 As the crisis continues to evolve, we are overdue a period of reflection on how health care professionals could be better positioned to tackle this hidden pandemic.

Clinical guidelines require frontline health care staff to screen and refer suspected cases of domestic abuse to specialist services.1 However, there is limited research appraising the quality and depth of training delivered to medical trainees to enable this. In a 2017 study, 75% of respondents from 25 of the 34 medical schools in the United Kingdom rated their teaching on domestic violence as ‘inadequate’.4 Although 84% responded that domestic violence teaching was present in the curriculum, 52% reported 0–2 hours of teaching across the whole 5-year degree, most often delivered during primary care modules.4 As trainees at three distinct UK medical schools ourselves, we have also received no formal training on screening and management of domestic abuse. Evidently, we are not alone. Such a deficit in the undergraduate curriculum is alarming. When teaching leads were queried over reasons for this, explanations included practical constraints on the curriculum, such as time.6 However, some leads disclosed they believed that domestic violence was not really a clinical issue, with the assumption that the knowledge and skills would be acquired elsewhere.

In addition to physical and psychological trauma, domestic abuse often obstructs victims’ ability to seek medical attention. For example, perpetrators are known to monitor or restrict access to health care out of fear of discovery.2 Quarantine measures have also further restricted movement and victims’ access to support.3 However, as the next generation of doctors, without adequate training we are simply not equipped to recognise and manage these situations in the workplace, especially during the pandemic. For these reasons, we argue that formal teaching on domestic abuse should be a priority, as we have a moral and professional duty to safeguard any vulnerable person in our care.

As medical students, we firmly believe a proactive approach is required to improve domestic violence training within medical schools, and this starts by addressing barriers to teaching. A significant proportion of medical schools delivers domestic violence training in a more traditional and didactic lecture format.4 We suggest a shift towards simulation-based teaching would help break down psychological barriers preventing students from effectively screening for abuse. The most common barriers reported by US medical...
students were internal, such as finding the topic awkward or being unsure of how to word questions and respond to a positive screening result. Therefore, clinical tutors could provide students direction on how to manage suspected cases of abuse, such as discreet reporting to seniors and referring patients to specialist support services. Additionally, facilitating small-group teaching creates a space for students to practice their history-taking skills under supervision in a non-judgemental environment. Doing so builds their capacity and instils the confidence students need to incorporate domestic abuse screening into consultations.

We firmly believe a proactive approach is required to improve domestic violence training within medical schools.

Given the complexity of how domestic abuse cases present to health care services, multidisciplinary training is also important. While primary care is a common setting for delivering teaching, other opportunities include rotations in emergency medicine, psychiatry and obstetrics and gynecology (O&G). For example, as women are disproportionately affected by domestic abuse, O&G placements may be especially suited for training, as sensitive topics like taking sexual histories are approached more organically. Furthermore, since pregnancy increases the risk of domestic abuse, antenatal appointments are also appropriate settings for screening. Finally, domestic abuse is an important area for interprofessional education. Health care professionals such as midwives and nurses are often first-line responders to patients seeking medical assistance. Therefore, training should be delivered to promote cross-disciplinary communication within health care teams. Our recommendations are summarised in Box 1.

Training should be delivered to promote cross-disciplinary communication within health care teams.

Domestic violence is a major public health challenge which has been exacerbated by the COVID-19 pandemic response. Given our moral and legal obligations to support those patients affected by domestic abuse, a multidisciplinary response is required to tackle this complex issue. It is therefore paramount that future health care workers are provided with the knowledge and meaningful learning experiences required to identify and protect these especially vulnerable members of the population.

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