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POSITION PAPER

Combatting Sexual Assault: Addressing Gaps in Medical School Curricula

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INTRODUCTION

Sexual Assault (SA) remains a prevalent offence in Canada, having widespread impact on individuals across the country. Close to 4.7 million, or approximately 30%, of all Canadian women have been victims of SA outside of an intimate relationship since the age of 15.[1] SA is associated with acute and long term health complications which may include genital and extragenital injury, sexually transmitted infections (STIs), human immunodeficiency virus (HIV), and unintended pregnancy, to name a few. Recent studies have also shown that individuals who experience an event of SA are more likely to develop somatic disorders, such as irritable bowel syndrome, frequent headaches, or chronic pain, compared to those who have not experienced SA.[2] The most prominent complications following SA, however, tend to be psychological symptoms. Fear, nightmares, or shame often occur immediately following an event of SA, with some patients reporting a type of memory loss known as dissociative amnesia, which is linked to acute stress disorder and posttraumatic stress disorder.[3] As a result, seeking medical care following an incident of SA is crucial to ensuring access to forensic examination, STI testing and prophylaxis, treatment of assault-related injury, and psychological care. Despite this, very few victims disclose their assault to healthcare providers (HCPs) due to numerous barriers, including shame, limited resource accessibility, discrimination, and lack of sensitive care.[3]

Fear and distrust of authorities or institutions are often intensified where oppressive systems intersect.[3] The Canadian healthcare system is an example of this type of institution, there is structural racism that exists within policies which has amplified health disparities and negative experiences.[4] As such, survivors with disabilities, those who are BIPOC, members of the LGBTQ+ community, and persons of differing socioeconomic status and religious backgrounds have been shown to encounter unique obstacles to disclosing and accessing SA resources. For example, members of the LBGTQ+ community may be less likely to disclose an assault and seek care due to fear of hate, discrimination, or the perception that they are not real victims.[3] Research has demonstrated that negative, dehumanizing biases towards LGBTQ+ individuals who report SA continue to persist, demonstrated by victim blaming, and downplaying the psychological or emotional outcomes experienced by LGBTQ+ victims when compared to straight, cisgendered individuals.[5] In Canada, Indigenous women are approximately three times more likely to experience SA than non-Indigenous women. In addition, the assault experienced has a higher incidence of serious physical injury, bodily harm, and other health related consequences.[6] Despite this, there is evidence to suggest that Indigenous SA survivors are less likely to seek medical care, but more likely to be referred to services such as safe planning support and child protection agencies.[7] Evidently, discrimination towards marginalized populations at individual and systemic levels is a significant barrier to the utilisation of SA care services. It is our position that addressing these barriers requires specialized, comprehensive training for HCPs that is rooted in principles of anti-oppression.

With this knowledge, it is imperative that all HCPs are provided with sufficient education and training to be able to deliver thorough, trauma-informed care to victims in acute clinical settings. The online curriculum entitled Addressing Past Sexual Assault in Clinical Settings was launched in 2015 and completed by a diverse group of frontline HCPs in Ontario, including nurses, therapists, radiation technologists, and addiction counsellors.[8] The introduction of this optional curriculum was found to address gaps in the education of HCPs surrounding sexual violence. By combining thoroughly researched tools from published literature with the firsthand experiences of HCPs, analysis revealed that upon completion of this curriculum, there was significant improvement in participant knowledge and competency when treating victims of SA.[9] A similar project for medical students was launched in the United States at Rush Medical College.[10] Students participated in a training program that introduced interview techniques that promoted an empathetic response to SA disclosures and the collection of key medical findings without retraumatization, and empowered patients to take autonomy of their care. This was completed through a focused lecture followed by small group practice of the skills discussed. Pre- and post-instruction evaluation revealed that the training led to significant improvement in comfort providing comprehensive trauma-informed care, as self-reported by the medical students.[10] Moreover, Wayne State University School of Medicine conducted a quantitative quasi-randomized trial which delivered an hour lecture to fourth year medical students. This lecture was created in collaboration with Wayne State County Sexual Assault Forensic Examiners (WC-SAFE) and included details not limited to: local resources, legal implications, evidence collection, documentation, treatment and neurobiologic effects. Two checklists were used to evaluate each group, the Kalamazoo Essentials Elements Communication Checklist assessed communications skills while the second checklist, developed by WC-SAFE, assessed participants SA knowledge. It was found that the students who attended the lecture were more prepared to provide trauma-informed care for SA victims than those who did not.[11] These studies illustrate the success of comprehensive training programs in promoting effective and empathetic SA care. Accordingly, we believe that SA care among Canadian medical learners could be vastly improved with the addition of such training programs into medical school curricula.

The Medical Council of Canada (MCC) is the governing body that directs curriculum objectives at Canadian medical schools. Currently, the MCC outlines three learning objectives surrounding SA. Interestingly, these objectives are only presented within the context of adult or intimate partner abuse. The first of these objectives involves interpreting critical findings, such as identifying individual and contextual risk factors for patient abuse and partner violence, as well as assessing a patient's risk of immediate danger. The next objective entails the appropriate interpretation and documentation of physical examination findings. The final objective encompasses the management of the patient, including providing empathetic care, confidentiality, support services and follow-up.[12] Upon reviewing these MCC objectives on the topic of SA, we have identified several areas of improvement that would increase the scope of the current curriculum. Specifically, the current objectives do not mention or detail the following components related to SA healthcare:

- Discussion of SA outside of an intimate partner setting
- Legal aspects of sexual assault domestic violence (SADV) evidence collection and reporting
- Conduction of an SADV physical exam including avoidance of retraumatization during evaluation
- Conducting trauma informed physical exams for survivors of SA
- Accessing resources for SADV care
- Mandatory inclusion of SADV advanced interviewing skills in practical/clinical skills coursework

These gaps in medical education transcend into practice and contribute to negative healthcare experiences faced by SA survivors when they present to hospitals and clinics across Ontario. It has been reported that women who face negative reactions from healthcare professionals and police upon disclosure often experience greater difficulty utilizing recovery supports and experience negative mental health outcomes to a greater extent.[13] We believe that incorporating a comprehensive SADV curriculum will be instrumental in fostering an understanding of the physical, psychological, and social impacts of SA by future physicians. Moreover, this will create an environment that supports disclosure and empowers future physicians with the knowledge to appropriately address SA during clerkship and beyond. While some large tertiary urban centers may have specialized SADV response teams, rural and remote healthcare settings

may not have these programs available. Currently, there are 37 hospital-based SADV treatment centers located across Ontario. These centers are excellent for providing comprehensive, trauma-specific care, but are only easily accessible in major cities and do not represent widespread knowledge of SADV care resources across the province. The advocacy group 'She Matters' conducted a 12-month study to determine Sexual Assault Evidence Kit (SAEK) accessibility across Canada. Of the 581 hospitals contacted throughout the course of the study, many emergency departments were not sure whether they had the resources to complete SAEK collection, with some stating that they did not have nurses or physicians trained to provide this specialized care. Hospitals that did provide services were overwhelmed by the volume of need and frustrated to be the only local facility capable of providing such care.[14] This lack of access to specialized care makes the inclusion of training within medical education even more relevant, and is thus crucial to ensuring medical students are prepared for these difficult encounters in clinical training. As a result, we believe that implementing comprehensive SADV training into medical education is necessary and will foster interdisciplinary and collaborative approaches to minimizing structural challenges (e.g. organizational commitment, time, and training). Overall, these changes will aim to ensure caregiver competence and optimize care for victims of SA, in both acute and future clinical settings.

PRINCIPLES

The Ontario Medical Students Association puts forward the following principles to guide recommendations for implementing comprehensive SADV training into medical education:

1. Given the prevalence of SA, its detrimental short term and long-term effects and the difficulty survivors face sharing their experiences, there is a pressing need to train future practitioners to become familiar with SADV interviewing, management, and resources.
2. Regardless of their field of training, medical students will likely encounter survivors of SADV. To proactively target internal barriers and biases, especially against marginalized communities, training around incorporating trauma informed and culturally safe care is vital.
3. Providing care to survivors of SADV can be immensely difficult. To encourage personal wellness, medical schools should equip students with tools to handle the emotional burden and vicarious trauma that are associated with providing SADV care.

These principles follow the core conditions of the Canada Health Act:

1. Universality, in that all students attending medical school in Ontario should receive comprehensive, high quality and client centered SADV training without discrimination.
2. Comprehensiveness, in that sex education should include SADV subjects that cover a wider range of relevant and essential topics, such as trauma informed physical exams and interviewing.
3. Accessibility, in that a comprehensive SADV curriculum should be available to all medical students in Ontario regardless of their school, socioeconomic status, faith, ethnicity or gender identity. This will work towards closing existing gaps as all Ontarians, regardless of their area of residence, should have access to high quality SADV care from the medical professionals to whom they courageously disclose.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

1. **That medical schools in Ontario should evaluate their course material to ensure the current MCC objectives related to sexual violence (114-3) are adequately addressed within current curricula.**

This recommendation is necessary to ensure that medical students across Ontario are receiving appropriate education on the topic of sexual violence. While gaps exist within the current curriculum objectives, these objectives cover topics that are imperative to providing safe and supportive care to those who have experienced SA. A study that assessed medical curricula in residency found that intimate partner violence was included as a topic in less than a third of the programs.[15] Additionally, a study that

reviewed undergraduate medical curriculum at the University of British Columbia found that while women's health topics, including sexual violence, were well covered, they could not determine whether these topics were actually delivered and to what extent.[16] Therefore, medical schools must review their curriculum content and delivery to ensure that students are learning the MCC objectives pertaining to Adult Abuse/Intimate Partner Violence. A thorough understanding of these objectives will help ensure that students are equipped with the knowledge and clinical skills that will make their patients feel safe. A positive healthcare experience may encourage patients to continue receiving necessary follow-up care to minimize the adverse outcomes associated with SADV. We recommend that the MCC review SADV curriculum content of all Canadian medical schools by June 31, 2023, to determine compliance with the stated objectives. Further to this, we also recommend that the OMSA support the development of a student review committee to give students the chance to provide their feedback on the SADV curriculum, in addition to review by MCC, to determine if learning materials are satisfactory from learners' perspectives.

2. **That the MCC objectives on sexual violence be updated to address current curriculum gaps by December 31, 2023.**

Medical education on SADV must be comprehensive in addressing factors related to the acute and long-term care of affected patients. There are several key concepts that the current MCC objectives fail to include, which are outlined above. These topics are necessary to provide detailed knowledge of SADV care, evidence collection and patient assessment, specifically within the context of the Canadian healthcare system. Thus, amendments should be made to broaden the scope of the existing sexual violence objectives (i.e., discussion of SA outside of an intimate partner setting). Moreover, additional objectives should be added to fill the existing gaps in the curriculum (i.e., mandate SADV standardized patient interview training). These changes will ensure that medical students are provided with practical SADV training, allowing them to become familiar with the extensive examination that SA survivors endure, while also learning how to support these patients and prevent retraumatization. We recommend that the MCC consult with a sub-committee of stakeholders, such as survivors and trauma support workers, to guide the development of these updated objectives. We recommend the OMSA support the development of this committee, as well as the development of a student committee to evaluate the updated SA learning objectives in 2024, after they have been implemented across all Canadian medical schools.

3. **That medical school curricula should address vulnerable communities and added barriers associated with sexual assault disclosure to healthcare professionals in order to optimize and inform patient care.**

While the utilization of SA care resources remains difficult for many due to stereotypes, myths, and lack of access, members of marginalized and rural communities are disproportionately affected by such biases.[3,6,7] Literature has shown that members of the LGBTQ+ community face more discrimination when disclosing SA.[3] It has also been shown that Indigenous women are disproportionately affected by SA, yet are less likely to seek medical care following an instance of assault. Moreover, those who do seek care are less likely to be satisfied with the quality of healthcare received from providers.[6,7] Therefore, the SADV curriculum should include a discussion of intersectionality and implicit bias training, as these factors affect the experience of patients and the quality and type of care provided.

These issues are even further magnified in rural communities, where SADV specialized care centers may not be widely available.[17] By ensuring all physicians are equipped to provide trauma-informed SADV care, individuals will be able to present to their local medical center and receive the care they need without the added stress of locating a specific resource outside of their local community. Therefore, SADV training that highlights barriers faced by marginalized communities will ensure that all individuals have access to the well informed and culturally competent care they deserve, regardless of their location, gender, sexual identity, race, religious affiliation, or ability. We recommend that the MCC consult with a sub-committee of stakeholders (ex. BIPOC survivors, rural survivors, LGBTQ+ survivors, trauma support workers) to ensure the curriculum is anti-oppressive and includes training on implicit biases. We recommend the OMSA

support the development of this committee, as well as the development of a student committee to evaluate the updated SA curriculum in 2024, after it has been implemented across Canadian medical schools.

4. **That medical schools should incorporate specific training on vicarious trauma and personal coping strategies as part of building a comprehensive sex education curriculum.**

In addition to the aforementioned recommendations, SADV education should also emphasize the emotional challenges that can occur with repeated exposure to trauma narratives. Research has demonstrated an increased susceptibility to vicarious trauma for those who treat survivors of sexual assault compared to other types of traumas.[18] The impact of indirect exposure to sexual trauma has been found to affect personal wellness in many ways, including an enhanced sense of personal vulnerability, cognitive disengagement, psychological distress and disrupted social relationships.[18,19] It can be especially triggering for students with a personal history of SADV. Therefore, medical schools should provide tailored resources to mitigate potentially negative effects of sexual assault trauma exposure. Effective coping and self-care strategies have been shown to have positive impacts on practitioners, promoting feelings of empowerment and posttraumatic growth.[20] We recommend that the MCC add these topics to the SADV curriculum by December 31, 2023. Further to this, we also recommend that the OMSA support the development of a student review committee once the curriculum is updated to determine if learning materials are satisfactory from learners' perspectives.

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