Family Violence Curricula in U.S. Medical Schools

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Introduction: Family violence (adult domestic violence, child abuse/neglect, and elder abuse) is endemic. Victims of family violence are seen in every venue of health care, yet physicians do not routinely inquire about abuse, even when patients present with obvious clinical characteristics. Although a comprehensive health care response is key to a coordinated community-wide approach to family violence, most practicing physicians have never received education in any aspect of family violence, including child abuse. This paper reports the results of a survey of family violence instruction in medical schools.

Methods: A written survey of medical school deans and student representatives of all 126 U.S. medical schools was conducted to (1) determine curriculum content in family violence, (2) assess differences between deans' and students' perceptions of curricular offerings, and (3) compare the results of the current survey with those of an earlier curriculum survey conducted in 1987.

Results: The majority of deans reported existing curriculum in all three topic areas of family violence. Compared to the 1987 survey, more deans reported existing curriculum in family violence. However, neither total instructional time nor curriculum during clinical training increased. Moreover, student and dean responses were discrepant regarding awareness of curriculum in domestic violence and elder abuse.

Conclusion: Despite an increase in the number of schools reporting curriculum in family violence, there does not appear to be increased attention to this problem, at least as measured by time devoted to teaching. Insights from this descriptive survey can promote ongoing efforts toward comprehensive curriculum development in family violence.

Medical Subjects Headings (MeSH): medical education, curriculum, domestic violence, child abuse, elder abuse (Am J Prev Med 1998;14:273–282)

Between 8% and 12% of American women are abused by intimate partners each year.[1] Ongoing abuse has been documented in 5.5% of female patients in adult primary care settings[2] and in 11.7% of women seen in emergency facilities,[3] with lifetime prevalences three- to five-fold higher.[2,3] Nationwide, the number of children reported for suspicion of child abuse/neglect increased by 50% between 1985 and 1993, when nearly three million children were reported to child protective services agencies.[4] National estimates regarding elder abuse range from 51,000 to 186,000 cases in a year,[5] although surveillance methodology varies from state to state.

More than 85% of Americans feel that, if asked, they could talk to a physician if they were a victim or a perpetrator of family violence.[6] However, battered women identify medical providers as the least effective professional source of help, despite frequent health care utilization.[7] Physicians do not routinely inquire about domestic violence during the medical history, even when women present with high-risk clinical characteristics. Abbott et al.[3] found that only 13% of women who presented for emergency care of acute domestic violence disclosed this history voluntarily or by staff query, and only 2.6% of all women seen in these emergency facilities for any reason were screened for ongoing or past domestic violence, despite a 54% lifetime prevalence of domestic violence in the study sample.

Family violence has been underrepresented in medical education. Leaders in medicine and public health have advocated for greater emphasis on family violence education for health care professionals.[8,9] However, the majority of physicians report having received no education about any aspect of family violence during medical school, residency training, or continuing med-

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Table 1. Deans' responses [N = 111 (88%)]

	Curriculum present (%)	No. of courses (%)					Median required hours *(range)*
		0	1	2	≥3	No data	
Adult domestic violence	95 (86)	15 (13)	39 (35)	24 (22)	25 (23)	8 (7)	2.0 (0–16)
Child abuse and neglect	105 (95)	7 (6)	39 (35)	37 (33)	22 (20)	6 (5)	2.0 (0–16)
Elder abuse	77 (70)	34 (31)	39 (35)	19 (17)	12 (11)	7 (6)	1.0 (0–10)

ical education.[10–13] Indeed, Sugg and Inui describe a lack of education as one of several barriers practicing physicians face in identifying and treating domestic violence.[10]

The first study to examine medical curricula in adult domestic violence found that the majority of American and Canadian medical schools did not provide any instruction on this topic in the 1987–1988 academic year.[11] The current study is a survey of U.S. medical schools 7 years later, to determine curriculum content in family violence, changes in instructional offerings since Holtz's 1987 survey, and to compare deans' with students' perceptions of curriculum content.

Methods

Dean and student representatives from all 126 accredited U.S. medical schools were asked to complete a written survey during the 1993–1994 academic year (Appendix 1). The survey instrument consisted of 9 multiple choice items soliciting information about curriculum content and/or barriers to curriculum inclusion in three topic areas: adult domestic violence, elder abuse, and child abuse and/or neglect. One additional multiple choice question asked about instruction in homicide, sexual assault, and assault on homosexuals. The survey instrument also contained a one-page grid on which respondents were asked to provide more detailed information about curriculum content, including: course title(s); curricular year(s) offered; number of hours of instruction; name, title, and academic department of instructor; course format (lecture, small group discussion, clinical case seminar, field placement, other); and whether the offering was required or elective.

A survey was mailed to each medical school dean identified by the Association of American Medical Colleges Directory, with a request to assign completion of the survey to the dean, faculty representative, or administrator most knowledgeable about curriculum in family violence. To assess student perceptions of curriculum content, identical surveys were mailed to the Association of American Medical Colleges-Organization of Student Representatives (AAMC-OSR) delegates from each school. A second survey was sent to nonresponders; late nonresponders were contacted by telephone. Discrepancies in the data were clarified by telephone.

EPI INFO 6.0 was utilized for data entry. The SAS statistical package and data analysis system was used to produce tables of frequency counts and percentage values for individual variables, and to generate two-way cross tabulations. Cross tabulations were analyzed by McNemar's Test, a statistical method analogous to Chi-square used specifically for analysis of matched data sets, to determine the significance of observed relationships.

Results

Deans' Responses

Deans' responses are summarized in Table 1. Curriculum deans or their designates (referred to as "deans") from 111 schools replied, yielding a response rate of 88.1%. "Dean" respondents included: 1 dean; 70 assistant, associate, or vice deans; 12 faculty who did not self-identify as deans; 25 non-faculty administrative staff; and 3 unknown. One of the 111 respondents, an associate dean, returned a letter indicating his refusal to complete the survey.

Ninety-five deans (86%) indicated existing curriculum in adult domestic violence, 105 (95%) reported curriculum in child abuse/neglect, and 77 (70%) reported existing instruction in elder abuse. Analysis of the submitted grids revealed fifteen deans (13%) who reported no curricular offerings about adult domestic violence, 39 (35%) who reported material in one course, 24 (22%) in two courses, and 25 (23%) in three or more courses. Missing or uncodable data were noted in 8 surveys (7%). In the 67 schools (60%) that offered required instruction in adult domestic violence, the median required hours were 2.0, range 0–16. Most instruction about adult domestic violence took place during the preclinical years, in Introduction to Clinical Medicine or Behavioral Sciences courses. Only 26 schools reported required material on adult domestic violence in the clinical years.

Table 2. Students' responses [N = 99 (79%)]

	Curriculum present (%)	No. of courses (%)					Median required hours *(range)*
		0	1	2	≥3	No data	
Adult domestic violence	54 (54)	45 (45)	32 (32)	17 (17)	3 (3)	2 (2)	2.0 (0–35)
Child abuse and neglect	80 (80)	21 (21)	48 (48)	21 (21)	7 (7)	2 (2)	2.0 (0–10)
Elder abuse	38 (38)	59 (59)	29 (29)	7 (7)	2 (2)	2 (2)	1.0 (0–8)

Child abuse/neglect received somewhat more attention in the curriculum, compared to adult domestic violence. Analysis of the submitted grids revealed 7 deans (6%) who reported no courses or curricular offerings, 39 (35%) who reported material in one course, 37 (33%) in two courses, and 22 (20%) in 3 or more courses. Missing or uncodable data were noted in 6 returned surveys (5%). In the 100 schools that offered required instruction about child abuse/neglect, the median required hours was 2.0, range 0–16. Although 41 schools offered at least some required instruction in child abuse/neglect during the preclinical years, more attention to child abuse/neglect occurred during third-year clerkships in Pediatrics, with 49 schools reporting required material.

Students received less instruction about elder abuse, compared to both adult domestic violence and child abuse/neglect. Analysis of the submitted grids revealed 34 deans (31%) who reported no course material or curricular offerings, 39 (35%) who reported material in one course, 19 (17%) in two courses, and 12 (11%) who reported that three or more courses contained information about elder abuse. Missing or uncodable data were noted in 7 (6%) of returned surveys. For the 52 schools that offered at least some required instruction about elder abuse, the median required hours was 1.0, range 0–10.

Student Responses

Student responses are summarized in Table 2. Student representatives from 99 schools (79%) completed the survey instrument. The majority of students (58) did not indicate their year of study; however, most who did were third-year students. For students who responded to the questions about curriculum content, 54 (55%) reported being aware of instruction about adult domestic violence, 80 (82%) reported awareness of curriculum about child abuse/neglect, and 38 (39%) reported curricular offerings regarding elder abuse.

Analysis of the curriculum content grids submitted by the student respondents revealed the following: 45 students (45%) recalled no course offerings that addressed adult domestic violence; 32 (32%) reported knowing of one course in which domestic violence was addressed; 17 (17%) indicated that two courses contained material on domestic violence; and only 3 students (3%) reported that three or more courses contained information about adult domestic violence. Missing or uncodable data were noted in 2 surveys (2%). For schools in which students reported required curriculum addressing adult domestic violence, the median hours of instruction throughout the entire curriculum was 2.0, range 0–35. Similar to the deans' responses, students reported that most education about adult domestic violence took place during the preclinical years.

Students reported that child abuse/neglect was more widely addressed than adult domestic violence. Twenty-one students (21%) reported no courses of instruction that covered child abuse/neglect; 48 (48%) reported knowledge of one course; 21 (21%) reported knowledge of two courses; and 7 (7%) reported three or more courses that addressed child abuse/neglect. Missing or uncodable data were noted in 2 surveys (2%). In those schools in which students reported required curriculum on child abuse/neglect, the median hours of instruction throughout the entire curriculum was 2.0, range 0–10. Unlike the deans' responses, students reported that most education about child abuse/neglect took place during the preclinical years.

Similar to deans, students indicated that elder abuse received much less attention in the curriculum than adult domestic violence or child abuse/neglect. Fifty-nine students (59%) recalled no courses that discussed elder abuse; 29 (29%) reported knowledge of one course; 7 (7%) reported knowledge of two courses; and only 2 (2%) indicated that elder abuse was discussed in three or more courses. Missing or uncodable data were noted in 2 returned surveys (2%). In those schools in which students reported required curriculum addressing elder abuse, the median hours of instruction throughout the entire curriculum was 1.0, range 0–8. Students reported that most instruction in elder abuse took place during the preclinical years.

Dean/Student Matched Comparisons

Eighty-seven schools provided data from both deans and students; these data were analyzed separately (Table 3).

Table 3. Dean (D)student (S) matched comparisons (N = 87 paired responses)

	Curriculum present (%)		No. of course (%)										Median required hours (range)	
			0		1		2		≥3		No data			
	D	S	D	S	D	S	D	S	D	S	D	S	D	S
Adult domestic violence	74 (86)	49* (57)	12* (14)	37 (43)	30 (34)	29 (34)	18 (21)	15 (17)	21 (24)	3 (3)	6 (7)	3 (3)	2.0 (0–25)	2.0 0–35)
Child abuse and neglect	81 (94)	73** (85)	5 (6)	13 (15)	29 (33)	42 (49)	31 (35)	19 (22)	18 (20)	7 (8)	4 (6)	6 (6)	2.0 (0–81)	2.0 (0–10)
Elder abuse	60 (71)	35* (42)	24 (29)	49 (58)	34 (39)	27 (31)	12 (14)	6 (7)	10 (11)	2 (2)	7 (7)	3 (2)	1.0 (0–28)	1.0 (0–8)

*$P = 0.001$.
**$P = 0.033$.

We found significant differences when comparing deans' vs. students' perceptions about adult domestic violence and elder abuse curriculum content, and borderline significant differences in child abuse/neglect instruction. Eighty-six percent of deans as opposed to only 57% of students reported instruction in adult domestic violence (McNemar's Test 20.16, $P = 0.001$). Ninety-four percent of deans vs. 85% of students reported instruction in child abuse/neglect (McNemar's Test 4.57, $P = 0.033$). Seventy-one percent of deans vs. 42% of students reported curriculum in elder abuse (McNemar's Test 14.54, $P = 0.001$). Significant differences between deans and students were also found in regard to the number of courses reported in each of the three topic areas. However, in schools in which there was agreement between deans and students about the presence of curriculum in adult, child, and elder abuse, there was also general agreement about the total hours of required and elective instruction.

Barriers to Development and Implementation of Curriculum in Family Violence

In schools without current curriculum in at least one topic area, respondents were asked to select (from a list of choices) perceived barriers to instruction (Table 4). Regarding barriers to curriculum implementation in adult domestic violence and elder abuse, deans cited financial constraints, a lack of faculty approval, and a belief that such issues should be addressed on a case-by-case basis during clinical clerkships. Students expressed concerns about a lack of faculty expertise and inadequate institutional endorsement. Barriers to implementation of curriculum in child abuse/neglect are not reported because most institutions did offer instruction in this area.

Discussion

Compared to an earlier survey by Holtz and Hanes,[11] which examined curriculum content in adult domestic violence, the current study revealed an 18% absolute increase (60% vs. 42%) in the number of U.S. medical schools reporting required education in domestic violence. This increase is not substantially affected by methodologic differences between the two surveys, specifically the incorporation of elder abuse within adult domestic violence and the inclusion of Canadian

Table 4. Perceived barriers to instruction

	Adult domestic violence		Child abuse and neglect		Elder abuse	
	D (N = 15)	S (N = 32)	D (N = 6)	S (N = 13)	D (N = 33)	S (N = 47)
Lack of faculty expertise	1 (7)	10 (31)	0 (0)	1 (8)	1 (3)	12 (26)
Lack of faculty approval	3 (20)	5 (16)	1 (17)	1 (8)	4 (12)	4 (9)
Lack of institution endorsement	2 (13)	14 (44)	1 (17)	4 (31)	3 (9)	14 (30)
Lack of finances	5 (33)	4 (13)	3 (50)	1 (8)	5 (15)	3 (6)
Not school's role	0 (0)	3 (9)	0 (0)	1 (8)	0 (0)	5 (11)
Clinical clerkships	5 (33)	9 (28)	3 (50)	1 (8)	10 (30)	15 (32)
Residency training	2 (13)	2 (6)	1 (17)	1 (8)	4 (12)	2 (4)

medical schools in the analysis by Holtz and Hanes. Total instructional time remained constant in the 7 years between the two surveys, despite societal concern and expanding knowledge about the health effects of family violence.

While most schools offer education in all aspects of family violence, instruction still occurs predominantly in the first 2 years. However, it is primarily during the clinical years that students integrate and apply knowledge of medical and social problems to the clinical assessment and care of patients. Instruction that occurs in the preclinical years only, and is not adopted as a component of routine patient care by the residents or attendings with whom the students interact, might not be interpreted as important to patient care.[14]

We note with interest the disparity between what deans report they are teaching and what students report they are being taught in adult domestic violence and elder abuse. Students report fewer, and less substantial, educational offerings in these areas than do deans at the same schools. There are several possible explanations for this finding. First, curriculum about family violence may indeed be present, albeit marginalized to "off hours" in the schedule, such as late in the term or close to a major exam, when attendance may be lower. Second, most teaching about family violence is delivered as a single, stand-alone offering, and as such is not re-emphasized over time, multiple courses, or clinical settings. Single presentations are generally not integrated into a student's foundation of knowledge as effectively as learning that occurs in context, is reinforced over time, and is perceived as central to patient care. Third, students may not be fully aware of what is offered in the curriculum. We did ask student respondents to consult freely with fellow students in all four years regarding what is covered in the medical curriculum. Some third- and fourth-year students may have forgotten what was taught two and three years ago, whereas preclinical students may be unclear about what is offered later in the curriculum. Indeed, curricula may have changed since upper class students matriculated.

The study methodology itself may also have impacted our observations of differences between deans and students regarding curriculum content. Deans may be subject to reporting bias, responding positively to questions about family violence instruction, given recent calls for more education in this area. Students may be subject to recall bias, failing to discover or accurately remember curricular offerings. It is also conceivable that in the third and fourth years, clinical instruction may be so thoroughly embedded within patient care that neither students nor their teachers can identify when attention is focused on particular areas, such as family violence.

The emphasis on preclinical family violence instruction may contribute to the finding that nearly half of the students were unaware of the very curricular offerings reported by their deans. Stand-alone lectures and teaching venues that are far removed from a student's clinical experience are often not as effective as instruction modeled on real or likely clinical encounters.[15] Indeed, some students who have received regular and reinforced education about family violence in the preclinical years by committed and supportive faculty report that incorporating basic principles of screening, assessment, and intervention is not encouraged in clinical rotations, and in some cases is actually "trained out" by residents and attendings. These clinical teachers and role models may: (1) teach by negative example when they fail to routinely query about abuse, or (2) indicate to students that such inquiry is not important, will not do any good anyway, or should not be attempted, given the increasing time constraints of clinical practice.

These data provide insights regarding the timing and placement of curriculum in family violence. The efficacy of instruction was not addressed in this study. It is plausible, however, that the lasting impact of curricular offerings would be diminished if students don't realize they are receiving instruction in this field.

Although the number of medical schools offering curriculum in family violence has increased, the time devoted to teaching has not, and the results of current educational efforts have not yet been fully realized. Instruction should be integrated throughout all four years of medical education, delivered using a multidisciplinary approach within and across courses and clerkships, and seek the expertise and collaboration of a range of individuals and organizations that comprise a community-based response network. Medical schools can expand upon this collaboration by fostering partnerships with community and direct service organizations where service-learning opportunities to reinforce teaching about family violence can occur. The involvement of community-based professionals, particularly in law enforcement, legal services, victim advocacy, batterer intervention, elder services, and child protection, among others, should be sought in all phases of medical education.

Effective teaching about family violence requires imparting knowledge, skills, attitudes, and feedback, about how to efficiently, yet compassionately, evaluate patients' concerns in the context of evolving life circumstances. These essential components of medical education in family violence cannot be taught and reinforced appropriately in 1 or 2 hours over a 4-year time span. The physician learner needs to know how to ask the right questions, listen to the patient's responses and concerns, and offer information, advice, and support to patients of diverse cultures and different values. Students also need to be aware of, and indeed open to examining, their own attitudes, beliefs, and personal

histories regarding family violence. Faculty development efforts should recognize and address these unique challenges.[16]

Conclusion

Family violence has clearly become better identified as a problem legitimately in the domain of health care. Competence in screening, assessment, intervention, and referral for adult domestic violence, child abuse/neglect, and elder abuse, is now part of the expected standard of care for graduating and practicing physicians. Medical educators have an opportunity to develop curricula to address this new area of medical practice, and ultimately to reduce violence in society.

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FAMILY VIOLENCE CURRICULUM STUDY

Respondent's Name: _____ Medical School: _____

Respondent's Title: _____ Telephone Number: ( ) _____

Please indicate your responses in the spaces provided

1. ADULT DOMESTIC VIOLENCE

This section of the survey is intended to assess curriculum content in your institution regarding Adult Domestic Violence.

Adult Domestic Violence (often referred to as partner violence, spouse abuse, battering, or wife beating among other terms) can be defined as intentional violent or controlling behavior by a person who is currently, or was previously, in an intimate relationship with the victim. Adult Domestic Violence encompasses a syndrome of coercive behaviors that may include, but are not limited to the following: (1) actual or threatened physical injury; (2) sexual assault; (3) psychological abuse; (4) economic control, and/or (5) progressive social isolation.[1]

1. **Do medical students at your institution receive any instruction about Adult Domestic Violence?**

   ❒ Yes

   ❒ No

   If you checked "yes" to Question 1, please provide curriculum content information by filling in the table on page 6.

2. **If your school does <u>not</u> currently offer instruction in Adult Domestic Violence, check the appropriate response:**

   ❒ Under development, to be implemented *within 12 months*

   ❒ Under development, to be implemented in *greater than 12 months*

   ❒ Not currently under development

3. **If your school does <u>not</u> currently offer instruction in Adult Domestic Violence, what is (are) the reason(s)? Please check all that apply:**

   ❒ Lack of faculty expertise [ ]

   ❒ Lack of faculty approval [ ]

   ❒ Lack of institutional/administrative endorsement [ ]

   ❒ Lack of financial resources to develop [ ]

[1] Alpert, E.J., Freund, K.M., Park, C.C., Patel, J.C., Sovak, M.A., *Partner Violence, How to Recognize and Treat Victims of Abuse. A Guide for Physicians*, Massachusetts Medical Society, 1992.

❒ Belief of the medical school that it is not its role to educate students about Adult Domestic Violence [ ]

❒ Belief of the medical school that Adult Domestic Violence is a medical issue, but should be addressed on a case-by-case basis during the clinical clerkships [ ]

❒ Belief of the medical school that Adult Domestic Violence is a medical issue, but should be addressed during residency training [ ]

❒ Other (please describe) [ ]

_____

_____

II. ELDER ABUSE

This section of the survey is intended to assess curriculum content in your institution regarding Elder Abuse.

Elder Abuse can be defined as either an act or an omission (the failure to act) by another person that results in or poses a significant risk of serious physical or emotional injury to an elderly person. The term Edler Abuse includes physical, sexual and emotional abuse, neglect and financial exploitation.[2]

4. Do medical students at your institution receive any instruction about Elder Abuse?

❒ Yes

❒ No [ ]

If you checked "yes" to Question 4, please provide curriculum content information by filling in the table on page 6.

5. If your school does <u>not</u> currently offer instruction in Elder Abuse, check the appropriate response:

❒ Under development, to be implemented *within 12 months*

❒ Under development, to be implemented in *greater than 12 months*

❒ Not currently under development [ ]

6. If your school does <u>not</u> currently offer instruction in Elder Abuse, what is (are) the reason(s)? Please check all that apply:

❒ Lack of faculty expertise [ ]

❒ Lack of faculty approval [ ]

❒ Lack of institutional/administrative endorsement [ ]

❒ Lack of financial resources to develop [ ]

❒ Belief of the medical school that it is not its role to educate students about Elder Abuse [ ]

❒ Belief of the medical school that Elder Abuse is a medcical issue, but should be addressed on a case-by-case basis during the clinical clerkships [ ]

[2] Mass. G.L. 19A, sec. 14–26.

❒ Belief of the meddical school that Elder Abuse is a medical issue, but should be addressed during residency training [ ]

❒ Other (please describe) [ ]

_____

_____

III. CHILD ABUSE AND NEGLECT

This section of the survey is intended to assess curriculum content in your institution regarding Child Abuse and Neglect.

Child Abuse can be defined as the non-accidental commission of any act by a caretaker upon a child (individual under age 18) which causes, or creates a susbstantial risk of physical or emotional injury, or any sexual contact between a caretaker and a child under the care of that individual. This definition in not dependent upon location (i.e., abuse can occur while the child is in an out-of-home or in-home setting).[3]

7. Do medical students at your institution receive any instruction about Child Abuse and Neglect?

❒ Yes

❒ No [ ]

If you checked "yes" to Question 7, please provide curriculum content information by filling in the table on page 6.

8. If your school does not currently offer instruction in Child Abuse and Neglect, check the appropriate response:

❒ Under development, to be implemented *within 12 months*

❒ Under development, to be implemented in *greater than 12 months*

❒ Not currently under development [ ]

9. If your school does not currently offer instruction in Child Abuse and Neglect, what is (are) the reason(s)? Please check all that apply:

❒ Lack of faculty expertise [ ]

❒ Lack of faculty approval [ ]

❒ Lack of institutional/administrative endorsement [ ]

❒ Lack of financial resources to develop [ ]

❒ Belief of the medical school that it is not its role to educate students about Child Abuse and Neglect [ ]

❒ Belief of the medical school that Child Abuse and Neglect is a medical issue, but should be addressed on a case-by-case basis during the clinical clerkships [ ]

[3] 110 Code of Massachusetts Regulations Pt. 2.00.

❒ Belief of the medical school that Child Abuse and Neglect is a medical issue, but should be addressed during residency training [ ]

❒ Other (please describe) [ ]

_____

_____

IV. ADDITIONAL TOPICS

10. Do students receive specific instruction or training in the medical curriculum regarding any of the following topics? Please check all that apply:

❒ Homicide [ ]

❒ Date rape [ ]

❒ Sexual assault [ ]

❒ Assault on homosexuals [ ]

❒ Other (please describe) [ ]

_____

_____

If you checked any of the above topics, please provide curriculum content information by filling in the table on page 6.

Please use the reverse side of this page to make comments and/or to indicate your name and mailing address if you would like to receive a copy of the results of this survey. Thank you very much for your assistance.

Curriculum Content[a]

	Course Title(s)	Curricular year(s) offered	Number of hours of instruction	Name, title, and academic department of instructor	Elective or required course (E/R)	Course format[b]
Adult domestic violence						
Elder abuse						
Child abuse and neglect						
Additional topics[c]						

[a] If possible, please enclose a description, outline or handouts from the course(s).
[b] Course Format: lecture (L), small group discussion (D), clinical case seminar (S), field placement (P), other (O). If other (O), please describe on the reverse side of this page.
[c] Curriculum content regarding homicide, date rape, sexual assault, and assault on homosexuals.