long way from being able to label any cigarette as less hazardous. That will be possible only when we have learnt enough about the basic mechanisms of the main smoking related diseases to be able to eliminate the causative factors from cigarette smoke.

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# Women victims of domestic violence

## *Treatment should extend beyond the obvious physical trauma*

Women's health is seen by many as screening for cervical and breast cancer or the provision of hormone replacement therapy.[1] Others have provided a much wider perspective: the Australian government has published its national women's health policy, which embodies the World Health Organisation's definition of health as a state of complete physical, mental, and social wellbeing and not merely the absence of disease and infirmity. Violence against women is identified as a priority along with reproductive health and sexuality, health of aging women, women's emotional and mental health, occupational health and safety, and the health needs of women as carers.[2]

The extent of domestic violence—the preferred term according to a recently published report—remains unknown. That review states that violence is infrequently reported to the police and that in the absence of large population studies only estimates can be given.[3] One such estimate is that each year half a million women are victims of domestic violence in England and Wales.[4] Some kind of physical violence has been said to occur in 20-30% of marriages[5] whereas other studies have concluded that serious violence occurs in 1%[6] to 5%[7] of marriages in Britain. Over 90% of victims are women. Even at the lowest estimate domestic violence affects the health of many women.

Many victims of domestic violence consult their doctors because of their injuries. The presenting complaint may be obviously related to violence—physical injury or depression—or be more obscure, such as pelvic pain following sexual abuse.[8] In one study, though 80% of women victims were examined by doctors, only a quarter disclosed that they had been beaten.[9] Many more hinted at an underlying problem, but the doctors confined themselves to treating the physical injury.

Doctors can, however, play a crucial part in helping victims by being aware that domestic violence occurs and by being prepared to ask key questions.[10] Information leaflets, such as those produced by Women's Aid, should be readily available in outpatient and casualty departments as well as in general practitioners' surgeries. In the United States the American College of Obstetricians and Gynecologists has taken the lead by producing a leaflet *The Abused Woman*[11] as part of its *Women's Health* series, which defines the problem and gives practical help about escaping from an abusive relationship and obtaining legal advice. Doctors should also be well informed about sources of help such as Women's Aid, social work departments, and community units and be prepared to refer women to these agencies. They should also keep accurate records of injuries sustained—not least for medico-legal purposes. As students they need to be taught in detail about the scale, forms, and consequences of domestic violence. No information is available about whether such teaching is included in the undergraduate training in Britain. In the United States a recent study to determine the curriculum content of adult domestic violence in 143 accredited United States and Canadian medical schools found that no instruction was provided in just over half of the 117 schools that responded. The others provided an average of 1·5 sessions lasting 1·9 hours.[12] New Jersey Medical School has taken the lead and has produced suggested hospital protocols and a training manual for health educators.[13]

An excellent review of domestic violence produced by the Home Office Planning Unit points out that an effective

response requires more than treating injuries.[3] Yet this does not happen partly because of "attitudes and beliefs about the 'proper' roles for men and women in relationships." These attitudes are ubiquitous and are held by the professionals who meet the victims of domestic violence. Progress will be made only when doctors not only deal with the immediate needs of victims but are also prepared to tackle the difficult task of looking for long term measures aimed at preventing domestic violence. That means identifying and then changing the conditions that give rise to it.

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# Training for general practice

## *No place for a national curriculum*

Planning the education of future general practitioners has to take account of many influences. The government has called for improved undergraduate and vocational training and it is demanding some form of accountability.[1 2] The profession wants a different form of audit[3 4] and has new ideas on what constitutes the knowledge base of medicine generally[5] and of primary care in particular.[4 6 7] The European Community Commission requires that by 1995 general practitioners of all member states should have completed vocational training[8-12] —and one consequence may be increased immigration from medically overcrowded neighbouring countries.

At present in Britain the quality of vocational training is very variable, as was highlighted in the furore[13 14] after the Joint Committee on Postgraduate Thinking in General Practice withdrew recognition of the North East Thames vocational training scheme in 1988.[15 16] The content is also varied: some training puts less emphasis on chronic disease,[17] management and communication skills,[11] and palliative care[18] than on acute conditions and specialties such as dermatology (M H Kelly, T S Murray, personal communication). Some commentators have argued that three years is not long enough for adequate training[11]; others seem satisfied.

In the current climate of opinion such variation is unsettling for planners. One solution that has been proposed is to agree a national curriculum, perhaps built upon *The Future General Practitioner*[19] and the examination for the membership of the Royal College of General Practitioners, already seen by many as a test of satisfactory vocational training. Such a curriculum may be superficially attractive and seem a road to consensus, but consensus often means a compromise that suits nobody and one which may stultify the education process by the dullness of uniformity.

What young general practitioners need is teachers who know the difference between training, which fills the knowledge pot, and education, which lights the fire under it, and who will allow learners to develop the skills of communication and empathy so undervalued in present training[20] and practice.[21] Young men and women are entering general practice from a wide range of backgrounds, races, cultures, medical schools, and life experience.[22] Soon these differences may be swelled by imports from Europe.[8 10 12] How could a common curriculum be devised for so diverse a group of graduates?

To make sense of educating this highly disparate group we must think not of where we are trying to go but where we are starting from. Any curriculum laid down in advance might easily result in new graduates being taught what they already know while leaving many aspects of ignorance untouched. We need to test trainees before they start their vocational training, to measure the needs of entrants so that individual teaching may be offered to every trainee. General practice, with its unique opportunities for one to one teaching, is the only place where individual curricula could work: but that assumes that individual need would be accurately assessed at the outset of what may have to be a longer course. If the present rate of 25 applicants for each place increases then a pretest may also offer a useful method of selecting trainees.

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