check

Independent learning program for GPs

Unit 578
December 2020

Medico-legal

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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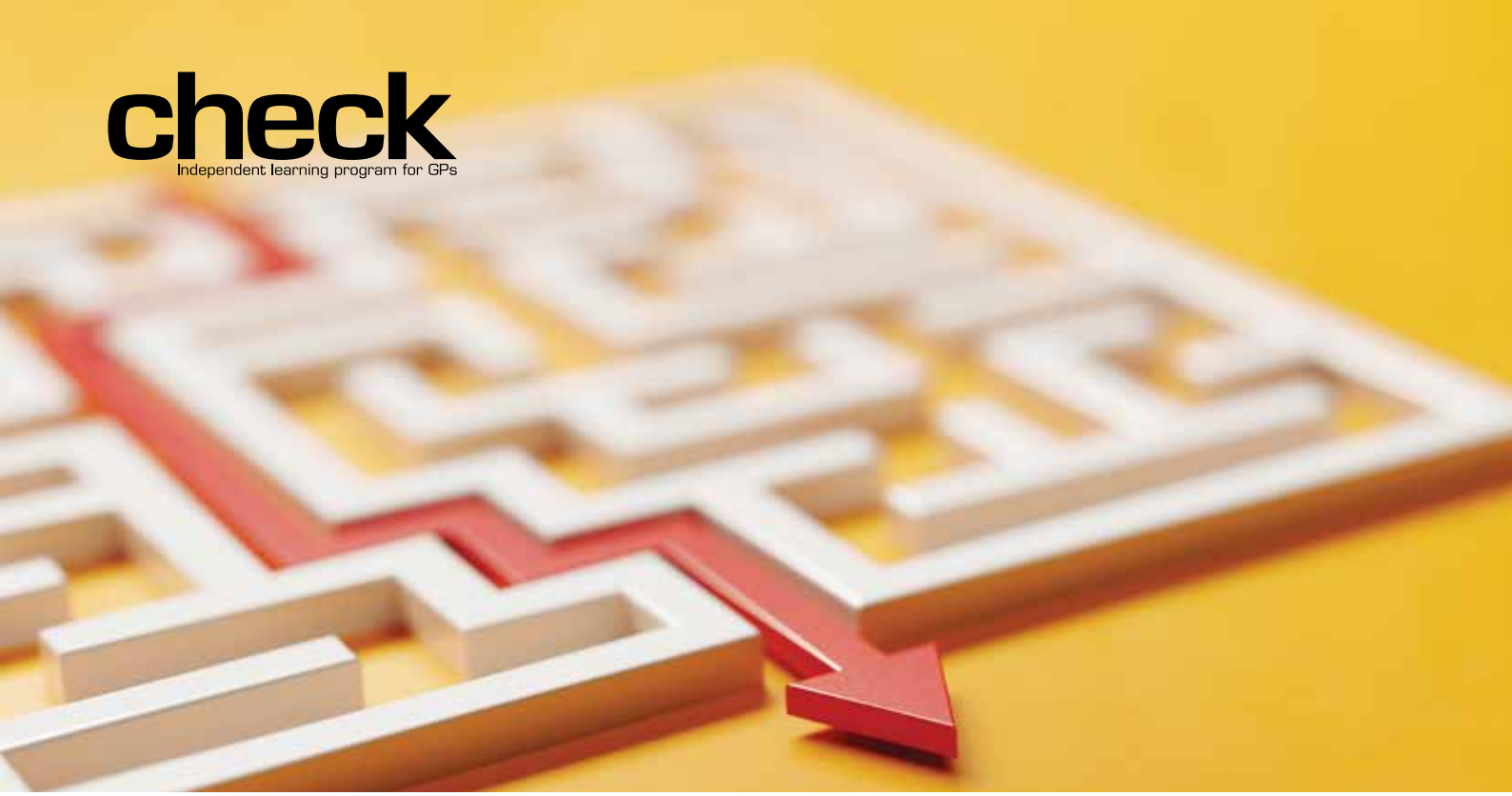

Medico-legal

Unit 578 December 2020

The five domains of general practice

- Communication skills and the patient–doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP

At-home diagnostics for seizure investigation

medicare
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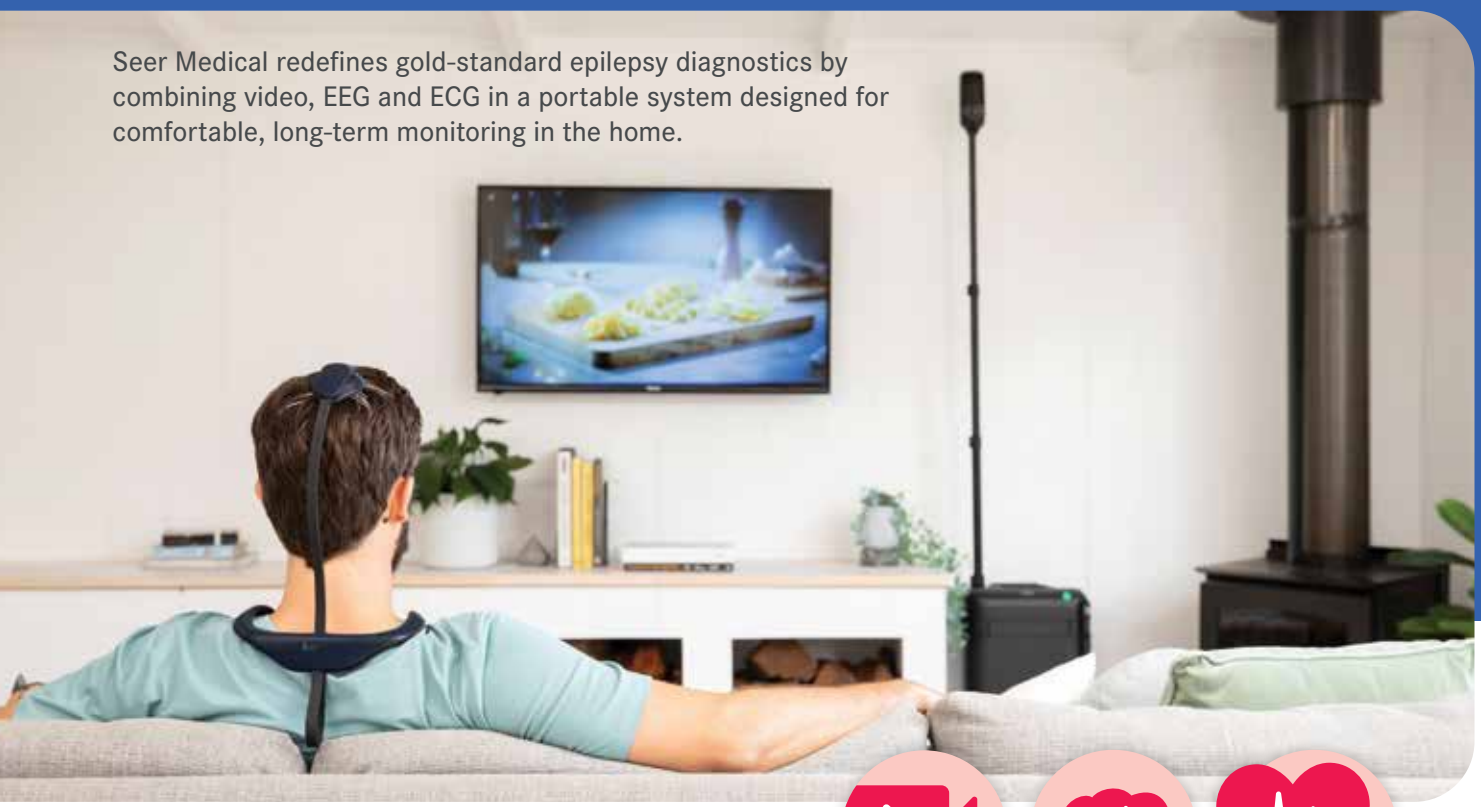
Seizures associated with loss of awareness, even if brief or subtle, or loss of motor control, have the potential to impair the ability to control a motor vehicle.[1]

Seer Medical redefines gold-standard epilepsy diagnostics by combining video, EEG and ECG in a portable system designed for comfortable, long-term monitoring in the home.



Assessing fitness to drive

Video-EEG-ECG monitoring may assist in the classification of seizures by:

- Identifying the underlying cause of events of impaired awareness, unresponsive episodes or loss of consciousness
- Determining whether seizures are limited to sleep-only
- Characterising the nature of patients' seizures
- Assessing seizure activity in response to treatment

Video

Helps to determine the specific nature of events from a clinical perspective.

EEG and ECG

Help to differentiate between a cardiac or neurological basis for patients' reported events.

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For more information

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seer medical

Reference: 1Assessing Fitness to Drive 2016
https://austroads.com.au/drivers-and-vehicles/assessing-fitness-to-drive

About this activity

Forensic medicine is at the interface of medicine and the law, contributing to knowledge and service delivery in both fields. General practitioners (GPs) are often the first contact for patients who will later use or interact with a forensic medical service.

Data from the 2016 Australian Bureau of Statistics (ABS) Personal Safety Survey indicated that 17% of women and 4.3% of men aged >15 years had ever experienced sexual assault.[1] Intimate partner sexual assault, child sexual abuse and sexual harassment are the most common forms of sexual violence.[2]

It is estimated that a full-time GP sees five women each week who have experienced intimate partner abuse in the past year.[2] The prevalence of elder abuse is estimated to be between 2% and 14%, with higher rates of neglect.[3] The GP's role is to both respond to the immediate abuse and manage the long-term consequences of assault.

A GP may be called on to give advice regarding a patient's fitness to drive. It has previously been shown that GPs were concerned about the impact on the doctor–patient relationship, among other challenges associated with this type of presentation.[4]

Under-reporting of deaths to the Coroner is a significant issue. One study of deaths referred to the Coroners Court of Victoria by the Registry of Births, Deaths and Marriages found that 48% were reportable and required a major change, and only 3% did not require alteration.[5]

The delivery of a medico-legal service requires practitioners to have an awareness of the ethical issues, relevant laws and management options for what is often a very vulnerable patient cohort.

This edition of *check* considers the recognition, documentation and early management of medico-legal presentations.

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Learning outcomes

At the end of this activity, participants will be able to:

- discuss the factors that would be considered when determining whether a death is reportable to the Coroner
- outline the approach to managing a patient presenting following a sexual assault, with a focus on an underage patient
- describe the signs on presentation that may indicate that injuries have occurred as a result of intimate partner violence
- outline the information that would be included in a statement to the police regarding an incident of elder abuse
- identify the general practitioner's responsibilities when determining a patient's fitness to drive.

Authors

Coordination and review, all cases

David Wells MA, FRACGP, FFCFM (RCPA) developed the international post-graduate program in Forensic Medicine at Monash University. He retains a role at the Victorian Institute of Forensic Medicine, though his recent activities have been as a consultant to the World Health Organization and the United Nations Office on Drugs and Crime.

Case 1

Kerryn Moreira MBBS, FRACP is a General Paediatrician at the Victorian Forensic Paediatric Medical Service and Werribee Mercy Hospital. She has special interests in the primary assessment of children who have experienced abuse and/or neglect and in the management of acutely unwell children.

Cases 2 and 3

Rachel Marr MBBS (Hons), FRACGP is a General Practitioner and Forensic Physician at the Victorian Institute of Forensic Medicine. She has an interest in the management of family violence within forensic and general practice settings.

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Case 4

David Ranson LLB, FRCPath, FRCPA is a Forensic Pathologist and the Deputy Director of the Victorian Institute of Forensic Medicine. He is Adjunct Professor in the Latrobe University Law School and an Adjunct Clinical Professor in the Department of Forensic Medicine at Monash University where he teaches undergraduate and postgraduate subjects in medical law, death investigation and medical evidence.

Case 5

Sanjeev Gaya MForensMed, FFCFM (RCPA) is a Forensic Physician at the Victorian Institute of Forensic Medicine and Adjunct Senior Lecturer in the Department of Forensic Medicine at Monash University. His activities cover the full span of clinical forensic medicine. He is coordinator of the Traffic Medicine unit of Monash University's Master in Forensic Medicine and Medical Advisor to VicRoads.

Angela Sungaila JD, MForensMed, FFCFM (RCPA) is a Forensic Physician at the Victorian Institute of Forensic Medicine. She is an Adjunct Senior Lecturer in the Department of Forensic Medicine, Monash University, and is a Medical Advisor to VicRoads. She is Fellow of the Faculty of Clinical Forensic Medicine in the Royal College of Pathologists of Australasia and is a qualified lawyer.

Peer reviewers

Sara Bird MBBS, MFM (Clin), FRACGP has worked in the medico-legal area since 1998, and she is currently the Manager, Professional Services with MDA National. In this role, she assists general practitioners (GPs) in dealing with a variety of medico-legal issues, including medical negligence claims, complaints and coronial inquiries. Sara is the author of the *Medico-legal Handbook for General Practice* and the co-author of *Cautionary Tales* with John Murtagh. Sara's background is in general practice, having worked as a GP in Sydney.

Jane Deacon MBBS, DipChildHealth, DipWomensHealth has been employed as a medico-legal advisor at MDA National for the past 14 years. This role involves her in assisting members with medico-legal questions and the complaints process. Prior to joining MDA, she ran her own general practice, and continued part time in general practice until recently. She has a particular interest in doctors' health.

Abbreviations

CLL	chronic lymphocytic leukaemia
GP	general practitioner
HIV	human immunodeficiency virus
IPV	intimate partner violence
MCCD	Medical Certificate of Cause of Death
MCI	mild cognitive impairment
MoCA	Montreal Cognitive Assessment
OCP	oral contraceptive pill
STI	sexually transmissible infection

CASE

1 Ryoko is upset

Ryoko, aged 14 years, comes to see you in your practice on Monday morning. She usually sees a different general practitioner (GP) but requested an urgent appointment. Ryoko looks worried and upset. She tells you that at a party on the weekend a boy from school forced her to have sex.

Question 1

What are your goals for this consultation?

Question 2

What are the important elements to elicit on history?

Question 3

What constitutes child sexual abuse?

Further information

Ryoko tells you that she lives with her parents and is well supported by her mother, who is in the waiting room. Ryoko has always been a well child who enjoys school and sports. She commenced the oral contraceptive pill (OCP) 12 months ago to help reduce menorrhagia, and she remembers to take it most days. She often forgets to take the OCP during the school holidays.

Ryoko said that she was at a school friend's party on Saturday night and that they were drinking alcohol. She and one of the boys, aged 15 years, went outside and started kissing, and then he forced her to have sex with him.

You clarify that Ryoko means that penile–vaginal penetration occurred, most likely without a condom, and that Ryoko does not have any injuries. Ryoko is unsure if the boy ejaculated. Ryoko went straight home from the party and put all her clothes in the washing machine, had a shower and went to bed. Ryoko said that when she woke up on Sunday, she called her best friend and told her what had happened. Her friend convinced Ryoko to tell her mother, who wanted to go straight to the police; however, Ryoko was scared she would be in trouble for drinking alcohol and begged her mother not to. Ryoko's mother scheduled the doctor's appointment for today.

Question 4

What is your next step?

Further information

Ryoko agrees to undergo a forensic examination.

Question 5

Should you examine Ryoko's genitals in this consultation?

Question 6

What tests should be offered to Ryoko?

Question 7

What treatment should you provide in this consultation, and what follow-up does Ryoko require following this sexual assault?

Question 8

Should you notify a child protection agency about Ryoko?

Question 9

Are you mandated to notify police about the reported sexual assault?

Question 10

How does the perpetrator's age affect your advice and management?

CASE 1 Answers

Answer 1

Establishing a good rapport will help Ryoko to feel supported and keep her engaged throughout the assessment process. It is important to reassure Ryoko that she has done well in coming to see you. You should also aim for the consultation to:

- be therapeutic for Ryoko and meet her physical and mental health needs
- explore the need for protection from harm and consider your obligations as a mandated notifier of child abuse
- meet the needs of other potential parties such as police.

Answer 2

History of presenting complaint

It is important to confirm some details of the events, such as when and what happened.

Information should be sought about any current symptoms, particularly those that might reflect injuries or infection (eg pain, bleeding, dysuria). This information helps determine what treatment might be needed and if the patient is presenting within the recommended timeframe to be offered a forensic examination for the purpose of forensic sample collection (www.rch.org.au/vfpms/guidelines/Recommended_maximum_time_for_forensic_sample_collection_-_2019).[1] All children who present following an acute sexual assault should be offered a forensic medical examination. Children who present with symptoms and/or signs of genital trauma or infection, regardless of the time since the alleged assault, should be offered a forensic medical examination.

Background information

To provide the best possible support to Ryoko, it is important to understand her background. Questions should be asked about her past medical history, family history and social history including past involvement with statutory child protection agencies and police, current orders relating to residency and contact with family members, family violence and/or child protection.

The HEEADSSS Screen framework (**H**ome, **E**ducation and employment, **E**ating and exercise, **A**ctivities, **D**rugs and alcohol, **S**exuality and gender, **S**uicidality, depression and self-harm, **S**afety screen)[2] will assist you to obtain most of the important information required.

It may not be possible to obtain all of the background information during the first consultation. Establishing who is caring for and supporting Ryoko takes priority, as it is necessary to determine whether she is safe in her home and in the community. Establishing if Ryoko came alone to the medical appointment and in whom she has confided will help you to decide this.

The Royal Children's Hospital provides advice regarding sensitive questioning of an adolescent (www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient).[2]

Answer 3

Child sexual abuse refers to the involvement of a child (person aged <18 years) in sexual activity that violates the laws or social taboos of society and that he/she: does not fully comprehend; does not consent to or is unable to give informed consent to; is not developmentally prepared for and cannot give consent to.[3]

Answer 4

It is important to reiterate to Ryoko what a great job she has done coming into your practice this morning. Now is a good time to consider seeking advice from a local Forensic Medical Service involved in the care of adolescents. Your state or territory protocols might require you to refer the child to a specialist service or an emergency department for collection of forensic samples. Your local police station or emergency department will be able to guide you.

An explanation about the role of a forensic doctor may provide Ryoko with some reassurance. The forensic doctor asks similar questions to those encountered during a general practice consultation, conducts examinations looking for signs of trauma, collects forensic samples if required and offers treatment advice. Participation in the forensic assessment requires informed consent, which is obtained at the beginning of the consultation. Participation will not prohibit further management by the GP should Ryoko choose not to proceed with a forensic examination.

It is important to explain to Ryoko how authorities such as police could become involved. Police provide a secure chain of evidence by escorting all forensic samples from the forensic doctor to the laboratory for analysis. A forensic examination may not mean that Ryoko has to give a statement to police immediately if she does not want to. For example, a parent or child may choose to defer a statement to police until after the forensic examination if it is late at night or the child requests a specific support person to be present.

Answer 5

Whether the GP performs a genital examination depends on practice location and local protocols. In many regions of Australia, there are specialist teams that provide consultations for individuals who have been sexually assaulted. Early consultation with local experts is recommended before conducting a genital examination; this might mean Ryoko does not need to be examined twice and there is a reduced likelihood of specimens becoming contaminated. Unless there are injuries that need assessment and possible urgent treatment, examination of the patient can often be referred to the forensic examiner.

Answer 6

A pregnancy test should be routine in all post-pubertal girls who have been exposed to unprotected intercourse.

Sexually transmissible infection (STI) screening is also necessary, including:

- first-pass urine – testing for *Chlamydia trachomatis, Neisseria gonorrhoea, Trichomonas vaginalis* and *Mycoplasma genitalium*
- blood tests – testing for syphilis, hepatitis B virus, hepatitis C virus and human immunodeficiency virus (HIV) serology.

Answer 7

Medical management

Pregnancy prevention (levonorgestrel) should be considered for all pubertal and post-pubertal girls. Ryoko is on the OCP

but often forgets to take her pill. The decision to give Ryoko levonorgestrel should be made on the basis of her recent medication history.

Because there is a high community prevalence of chlamydia and gonorrhoea, the usual recommendation is that all victims of alleged sexual assault receive antibiotic prophylaxis at their first consultation. Azithromycin (1 g) is a common choice.

Hepatitis B virus and human papillomavirus immunisation should be considered in all unimmunised victims of sexual assault. Recommendations for HIV prophylaxis are individualised according to risk (www.rch.org.au/vfpms/guidelines/estimated-probability-of-aquiring-hiv).[4]

Psychological management

Ryoko should be referred to her local sexual assault counselling service or suitable alternative for psychological services. Ryoko should also be advised that she can self-refer at any time.

Follow-up GP appointments

Where possible, Ryoko's follow-up appointments should be aligned with the need for repeat STI testing. It is recommended that repeat testing occur at two weeks, six weeks, three months and six months after the assault.[5,6] Repeat pregnancy tests should also be considered at the two-week follow-up visit if menses has not occurred as anticipated.

Answer 8

No, this child is not at risk. She lives with and is supported by her family and is safe. Referral to child protection should be made when a child has experienced harm as a result of abuse or neglect and their parent or guardian has not or is unlikely to protect them.[7]

Answer 9

No. Although there is no law in Australia that requires you to report this sexual assault, you can support and encourage Ryoko to inform the police.

Answer 10

Regardless of the age of the perpetrator, this is a case of sexual assault.

The partner's age is relevant in cases of consensual sex when determining whether statutory rape occurred. The legislation for engaging in sexual behaviour with someone varies in each state and territory. The age of consent is 16 years of age in the Australian Capital Territory (ACT), New South Wales, Northern Territory, Queensland, Victoria and Western Australia. In Tasmania and South Australia, the age of consent is 17 years of age.[8] When the child is under the age of consent, variations are made to these laws based on the age of the child and the person/people with whom they are engaging in sexual activity. For example, in Tasmania it is a defence if the child was 15 years of age and the accused person was not more than five years older than the child, or if the child was more than 12 years of age and the accused person was not more than three years older than the child. In Victoria and the ACT, it is considered a criminal offence if the defendant was more than two years older than the person against whom the crime was committed if that person was between 12 and 16 years of age.[8] The obligation to report sexual abuse to police varies between the states and territories.[9]

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CASE

2 Tracy requests a medical certificate

Tracy, aged 36 years, attends your clinic. You notice she has not been to the clinic for almost 12 months, when she last attended seeking assistance regarding difficulties in her marriage that were causing her to become depressed. Tracy has no children and works full time as a nurse. She has come today to request a medical certificate for work, as she is in pain. She tells you she fell over last night and hurt her arm after she tripped over her dog. She has a noticeably hoarse voice. When you ask about this, she denies any upper respiratory tract infective symptoms. You can see part of a bruise between her collarbones, at the top of her blouse, and a small subconjunctival haemorrhage.

Question 1

How would you examine Tracy?

Further information

Tracy agrees to your request to examine her. On examination you observe that Tracy is alert, with a Glasgow Coma Scale score of 15. Her voice sounds hoarse. Her chest is clear with equal air entry. Her neck is tender on the left side, as is her scalp. While examining her eyes, you notice a small subconjunctival haemorrhage. You also observe several injuries on Tracy's neck, chest and arms (Figures 1–4).

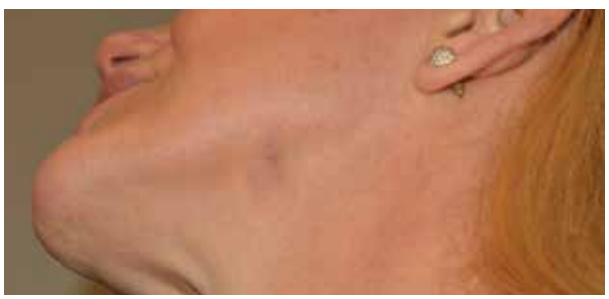

Figure 1. Tracy's neck injury

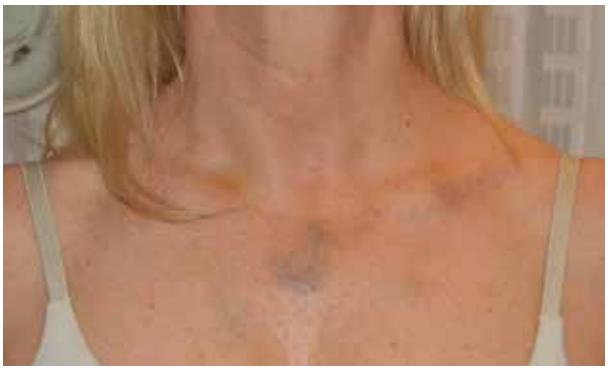

Figure 2. Tracy's chest injury

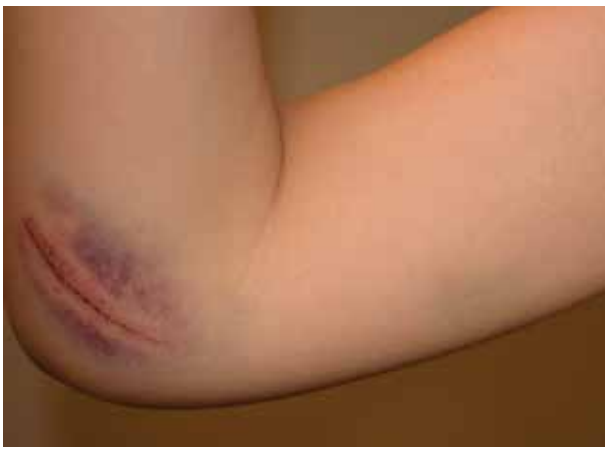

Figure 3. Tracy's arm injuries

Figure 4. Tracy's arm injuries

Throughout the consultation, you have developed good rapport with Tracy.

Question 2

What further questions would you ask about the injuries?

Further information

Tracy tells you that she tripped over her dog and is vague about providing any additional details of her injury circumstances. She tells you that she is otherwise in good health, with no medical conditions, and she takes no medications. When directly questioned about the relationship, she discloses to you that her husband has a quick temper if things do not go his way, but she does not elaborate on this. You suspect intimate partner violence (IPV) as the cause of her injuries.

Question 3

How would you approach this, and what further questions could you ask?

Further information

After some gentle but direct questioning, Tracy begins to cry and discloses to you that last night her partner became angry. She remembers him 'choking' her, squeezing both his hands around her neck tightly, and she could not breathe. She does not completely recall what happened after that and thinks she 'blacked out' for a while, but she recalls waking up to him hitting and kicking her. She lost control of her bladder during the incident. You ask about ongoing symptoms, and Tracy tells you she has severe pain on swallowing. Her voice still sounds hoarse.

Question 4

What is 'choking', and to what is Tracy actually referring? What would you look for specifically on examination after this disclosure?

Question 5

What are your immediate concerns and how would you manage them?

Further information

Tracy politely thanks you for your medical advice; however, she explains that she really needs to get home and is willing to accept the risk of developing complications. She says she does not think that she is at ongoing risk from her husband, as he has been very apologetic since the incident.

Question 6

What other elements of IPV might you ask about to complete a risk assessment regarding Tracy's going home?

Further information

Tracy discloses that her partner has two hunting rifles. He is very controlling and frequently calls and texts her during the day to ask about her whereabouts. She says that last night was 'her fault', because she had discussed separating with him, and she had noticed an escalation in violence in the preceding few days. She says that although he has always had a hot temper, this was the first time he had strangled her.

Question 7

What advice would you give Tracy regarding her safety, and what additional information could you provide?

CASE 2 Answers

Answer 1

It would be reasonable initially to examine Tracy for signs of respiratory infection in relation to the hoarse voice, for example, to look at the pharynx and palpate for cervical lymphadenopathy.

The observation of a bruise to the chest in conjunction with arm pain, a subconjunctival haemorrhage and hoarse voice should prompt a thorough clinical examination looking for evidence of other injuries. An examination looking for signs of neck compression (strangulation) specifically should also be conducted.

An examination after an alleged or suspected physical assault would ideally cover the entire body, though in the absence of reason to suspect sexual or physical assault to the breasts, genitals and/or buttocks, it would be reasonable not to examine them.

Given the suspicion of strangulation has been raised, examination should also be tailored to signs of complications from strangulation. Therefore, an assessment of Tracy's state of consciousness (using the Glasgow Coma Scale) and vital signs (especially respiratory rate) is recommended.

Examination of the head and neck, with particular attention paid to areas where injuries from neck compression can occur, would include looking for bruises or abrasions to the front of the neck or under the jaw, palatal petechiae, and bruising or abrasions to the rest of the face and behind the ears and neck. Looking through the hair at the scalp for bruises/haematomas and at the torso, arms and legs for any non-disclosed injuries is also recommended. Particular attention should be paid to areas that do not commonly sustain accidental trauma, such as the inner upper arms, inner thighs, axillae and chest/abdomen.

Answer 2

Although Tracy has given you an explanation for her injuries, the extent and nature of her injuries suggest other causes should be considered. She has multiple areas of bruising and abrasions primarily to her neck, chest and right arm. The neck and inner arm are relatively protected from accidental trauma. Her injuries suggest she has sustained multiple instances of blunt and abrasive trauma. Additional questions may include:

- Are there any pre-existing injuries that are unrelated (eg sporting injuries)?
- Are there any medical conditions or medications that may predispose to bruising?
- What analgesics has she already taken (if any)?

Clarification regarding the specific mechanism of injury is recommended – the appearance of the injuries suggests a simple fall is an unlikely cause. A complex fall (such as down stairs, with multiple impacts of blunt and abrasive trauma), a motor vehicle collision or an inflicted cause should be considered. Other questions to ask could include:

- What is her greatest concern at this point in time?
- Has anybody ever hurt her or made her feel unsafe?

Phrasing questions carefully may be of utmost importance. A suggested way of asking is, 'Previously when I have seen injuries such as these, they have been from someone causing the person harm. Is that what has happened here?'

Answer 3

Intimate partner abuse (often known as domestic violence) is any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and/or social harm to those in the relationship. An intimate relationship may refer to a current or previous partner or living companion, including same-sex relationships.

A general practitioner (GP) in full-time practice is likely to see up to five women per week who have experienced abuse in the past year.[1] Many agencies who work with victims of family violence are anticipating an increase in family violence incidents as a result of COVID-19 restrictions. Patients who experience IPV may present with a wide range of various ill-defined physical and psychological complaints.[1] If you do not specifically ask about it, patients will rarely disclose this information.

It can be useful to normalise asking about IPV with an opening statement such as, 'Violence is very common in the home. I ask a lot of my patients about abuse when I see injuries like these'.

Possible questions to ask and statements to make if you suspect intimate partner abuse are:[1]

- Has your partner ever physically threatened or hurt you?
- How do you resolve arguments?
- Sometimes people react strongly in arguments and use physical force. Is this happening to you?

- Are you afraid of your partner? Have you ever been afraid of any partner?
- Have you ever felt unsafe at home?
- Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partner.

A non-judgemental approach to discussing IPV is required, and it is important that clinicians feel confident and comfortable discussing this. If a patient discloses, the clinician should respond in a non-judgemental way and address safety concerns. Even if there is no disclosure made, the patient may disclose a history of violence at a later date if they feel safe with you and have established rapport. This also highlights the importance of careful documentation of injuries even when no disclosure of family violence is made. Victims of family violence may attribute their injuries to alternative mechanisms but report a physical assault at a later date.

Answer 4

Choking is the blocking of the airway due to a foreign object lodged/stuck in the throat/airway, internally obstructing airflow (eg choking on food). This term is often incorrectly used when referring to neck compression, or non-fatal strangulation, which is what Tracy has described.

Strangulation, or neck compression, is external compression to the neck. It can cause consequences that may be fatal as a result of compression of, and injury to, the vital structures in the neck such as the airways, blood vessels and nerves. Strangulation is a form of violence that may occur in physical assault, sexual assault and IPV.

It is vitally important for frontline practitioners to be aware that serious injury can occur without visible signs of external injury. There are often no visible signs of non-fatal strangulation. Symptoms may include:[2,3]

- neck pain
- difficulty swallowing
- coughing
- hoarse voice
- bladder and bowel incontinence
- light-headedness/headache/dizziness
- loss of consciousness
- memory loss
- visual changes
- seizures
- shortness of breath.

When present, resulting signs and symptoms can be from either the asphyxiation or blunt force injuries to the neck. It is important to examine behind the ears, in the mouth, under the jaw and around the eyes for injuries that may be hidden. When present, signs of strangulation may include:[2]

- subconjunctival haemorrhage (not specific to strangulation)
- petechiae above the site of application of force (usually on the face, around the eyes, oral mucosa and palate)
- bruising or abrasions to the neck
- red marks on the neck
- raspy or hoarse voice/loss of voice.
- noisy or difficult breathing and swallowing
- swelling of the neck, face or tongue.

In the context of the COVID-19 pandemic, relevant public health guidelines should be adhered to regarding patients with upper respiratory symptoms.

Answer 5

Tracy has disclosed to you that she has sustained manual neck compression, with loss of consciousness and urinary incontinence. She has a hoarse voice and describes pain on swallowing. She is at risk of complications of strangulation and requires assessment at a hospital emergency department.

While some victims of neck compression can provide an account of their assault, many are unable to because they may be affected by drugs or alcohol, distracted by other injuries or concerns, or have experienced a loss of consciousness that may have caused amnesia. There may be additional barriers to disclosure due to fear of repercussions. Many will not know if they lost consciousness. It can take only seconds of compression before a victim loses consciousness, and brain death will occur within minutes if compression is sustained.

The neck is vulnerable to external injury because it does not have bony protection and within its relatively small diameter course the vital structures for life. These vital structures include the airway, vascular supply to and from the brain, spinal cord and other vital nerves, and cervical vertebral column. Serious injury or death from strangulation can occur in multiple ways as a result of damage to these structures.

If the initial strangulation/neck compression is non-lethal and the injuries go unrecognised or untreated, delayed airway obstruction may occur as a consequence of late-onset swelling and bleeding. Life-threatening stroke via vessel dissection can also occur.[2]

The evaluation of neck compression is dependent on the history, symptoms and signs. It may include a period of observation, imaging studies such as a computed tomography angiogram, or ear, nose and throat review for laryngoscopy for evaluation of the vocal cords and trachea.

Answer 6

It is important to assess and manage the risk of family violence. Risk frameworks have been developed to help provide an integrated response to disclosures of family violence; they are available online for health professionals and modified for local use.[4] Asking the patient directly whether they feel safe to go home is a good starting question. Key issues to ask about to assess safety include:

- an escalation – an increase in severity and/or frequency of violence
- access to weapons, or having ever been threatened with a weapon
- a history of strangulation or attempted strangulation
- physical assault while pregnant or following birth
- controlling behaviours
- stalking
- sexual assault
- obsessive and jealous behaviour
- drug and alcohol misuse.

Answer 7

In addition to advising Tracy to attend an emergency department for medical assessment following non-fatal strangulation, it is important to discuss the high-risk features you have identified on your risk assessment (ie access to firearms, controlling behaviours, escalation, separation and strangulation) so Tracy is informed of her high-risk situation.

In addition to the immediate medical risks, Tracy is at elevated risk of future homicide. Prior non-fatal strangulation by an intimate partner has been found to be associated with greater than six-fold odds of becoming an attempted homicide, and greater than seven-fold odds of becoming a completed homicide.[5] It is recommended to explain to Tracy that non-fatal strangulation is an important risk factor for homicide of women by an intimate partner.

The option to report the incident to the police should be offered. Specially trained police officers can assist victims to access appropriate services and obtain emergency orders to provide immediate safety. Health practitioners should be aware of reporting requirements in their jurisdictions. In most states and territories, if the patient is a competent adult, as Tracy is, then it is the patient's right to decide their own pathway to safety. In the Northern Territory, it is mandatory to report serious domestic and family violence to police, including if you think the person is 'in danger of being hurt'.[6] Some states and territories have mandatory reporting laws for abuse that takes place in residential services, such as psychiatric, aged care and other government-run facilities, even if the person who has experienced the abuse is an adult. Mandatory reporting of child abuse is required throughout Australia, and in some states it is recommended that you make a report if a child has witnessed family violence.[1] Practitioners should seek specific advice regarding mandatory reporting requirements in their state or territory.[7]

1800 RESPECT (1800 737 732) is a 24-hour telephone line and website that can be provided to Tracy to connect her with advice and resources relevant to her local area. This may include crisis accommodation and counselling.

Even if Tracy does not wish to report the incident to the police on this occasion, she may change her mind in the future. Additionally, patients may present multiple times to their GPs with various injuries ascribed to accidents and disclose family violence at a later date. This highlights the importance of thorough contemporaneous documentation of injuries, with detailed descriptions of the clinical findings. In this case, the possibility of taking photographs to store in Tracy's clinical record should be explored. Thorough medical records can prove invaluable in investigations into historic family violence incidents and may assist the patient if they seek an intervention order at a later date.

Conclusion

Tracy agrees to have a medical assessment at the hospital and to call 1800 RESPECT to make contact with local IPV crisis services. With her permission, you contact the hospital emergency department to advise the admitting doctor of her expected attendance. Three months later, Tracy attends for review for an unrelated matter, and thanks you for the provision of information about local services that provided her with crisis emergency accommodation. She is receiving counselling and has since returned to work.

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CASE

3 Tom is distressed following an argument

Tom, aged 76 years, has been given an appointment as a 'walk in' patient. He seems somewhat distressed and a little angry. You have seen him previously for mild alcohol-induced cirrhosis without coagulopathy, organomegaly or varices. Tom's son has been living with him for six months. His son uses methamphetamine. They had an argument last night about his son's methamphetamine use, and Tom's son hit him with a stick of wood to his upper body (Figures 1–3) and pressed a knife against his neck (Figure 4).

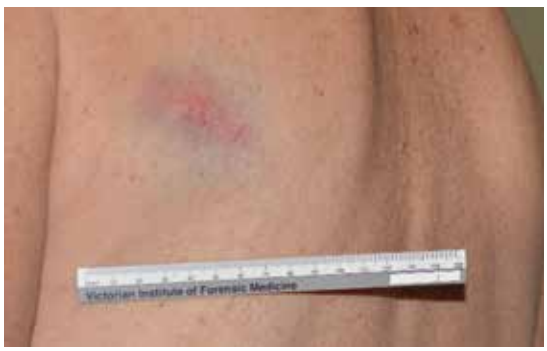

Figure 1. Bruising on Tom's back

Figure 2. Tom's body injury (back)

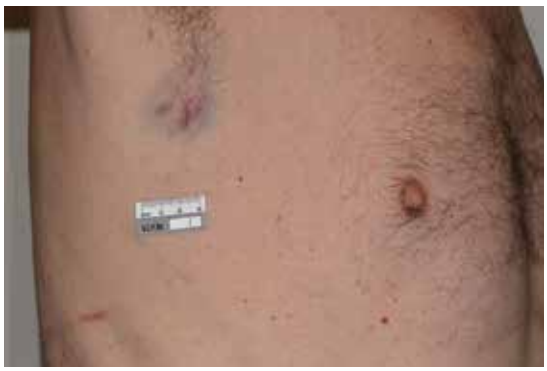

Figure 3. Tom's body injury (front)

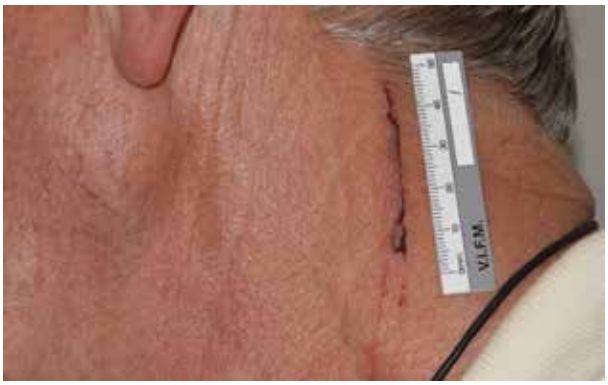

Figure 4. Tom's neck injury

Question 1

How would you describe the injuries to Tom, as shown in Figures 1–4?

Question 2

Given Tom's current presentation, what other forms of elder abuse might you look for? How would you go about identifying them?

Further information

Tom seems to fluctuate between being angry with his son and downplaying the extent of his injuries and reiterating that his son is a 'good boy'. When you ask about other forms of elder abuse, Tom discloses that sometimes he cannot find his credit

card, and that sometimes when he goes shopping his card gets declined. His son has also demanded money and threatened him with a knife at times. On direct questioning, Tom says he does not feel safe to go home right now because his son was 'acting like a crazy person'.

Question 3

What steps would you take to ensure Tom's safety?

Further information

Tom returns two weeks later for an Over 75 Health Assessment at your suggestion. You take the opportunity to discuss his current living circumstances, and he tells you that his son has moved out because Tom sought an intervention order and that the police have charged him. Since his son has moved out, Tom's daughter and grandchildren visit more regularly and he is feeling much better overall.

Question 4

What would be your approach if a police officer requested a statement from you about the cause of Tom's injuries?

CASE 3 Answers

Answer 1

Tom has sustained an incised wound, measuring approximately 4.5 cm, on the left side of the neck (Figure 4). A blue and purple bruise to the left shoulder blade, measuring 4–5 cm in diameter, is also visible (Figure 1). An abrasion shaped like a sideways 'u' is visible on the right side of the midback (Figure 2). The abrasion is surrounded by a 'halo' of purple bruising, with underlying blue bruising. A blue and purple bruise can be seen under the right axilla, measuring approximately 3.5 cm in diameter (Figure 3).

When describing injuries forensically, the following principles are helpful to keep in mind:

- document the type of injury (eg bruise, laceration), the location (eg distance from bony prominences) and approximate size
- remember that not all open wounds are 'lacerations' – injuries due to sharp trauma will usually have clean, straight edges without bruising and should be referred to as incised wounds
- conduct a thorough examination (with the patient's consent) and look for injuries that might otherwise be missed (eg under the jawline, in the mouth, behind the ears).

Injury categories and brief explanations follow.

Blunt trauma

Blunt trauma refers to a blow or impact with a blunt object or surface. Examples include punching, kicking, slapping, grabbing, hitting with a blunt implement or falling onto a blunt surface. Blunt trauma can cause no injury, or it can cause redness, bruising, lacerations or damage to internal structures such as bones or organs.

Abrasions

Abrasions are injuries to the top layers of the skin caused by blunt force or impact in combination with movement or traction across the skin. A scratch abrasion is caused by a narrow-edged object such as the tip of a tree branch or fingernail.

Bruises

Bruises are generally caused by blunt trauma in the form of an impact or pressure to the skin resulting in rupture or leakage of the blood vessels underneath. It is not possible to accurately determine the age of a bruise.

Laceration

A laceration is a split or tear of the skin (and possibly underlying soft tissues) as a result of blunt trauma. Lacerations will have characteristics such as irregular edges, uneven wound depth, tissue-bridging and possible associated bruising or abrasion.

Sharp trauma

Sharp trauma refers to injury sustained by an object with a sharp edge, such as a knife or glass.

Incision wounds

Incisions (or 'cuts') are injuries caused by a sharp implement or object such as a knife or glass. A stab wound is an incision that has greater depth than width.

Answer 2

Elder abuse can take many forms and, by definition, is the result of the actions or neglect of a person who has a familial or care-giving relationship with the elderly person. The sub-types of elder abuse and some of their accompanying signs are described in Table 1.

Note that delirium or dementia may produce false allegations of abuse.

Answer 3

Elder abuse in the home does not typically fall under mandatory reporting laws in Australia. Careful exploration of what Tom wants to do is a good place to start. Elder abuse is associated with significant morbidity and even mortality.[1] People who are victims of elder abuse have a greater risk of hospitalisation, early death, need for nursing home placement, chronic pain, financial hardship, disability and mental and physical illness.[1,2]

Often, people experiencing elder abuse do not want their abuser 'punished'.[3] There can be very mixed feelings, especially when a familial relationship co-exists. The elder can also be worried about nursing home placement or isolation from family, such as grandchildren. Furthermore, in the case of parent–child elder abuse, the elder may feel a sense of responsibility for their child's actions. Prior relationship disharmony and carer stress are significant risk factors for parent–child elder abuse.[4]

In Tom's case, it may be a good idea to advise him of local support services. A MyAgedCare assessment and arrangement of home help, Meals on Wheels, or other services to support him (if required) may help allay any worries Tom may have about how he will cope if he ceases living with his son. These services may also help to reduce carer stress in other cases where carer stress is likely to be the main driving force of elder abuse.

Tom may also appreciate an opportunity to discuss his options, including making a police report and seeking an intervention order. Explaining that continuing to live with his

Table 1. Types of elder abuse[6]

Type of elder abuse	Characteristics	Signs to look for
Psychological	• Threats (eg violence, being moved into nursing home) • Coercion (eg withholding contact with grandchildren and other family members, enforced isolation) • Embarrassment in front of others • Not being allowed to make own decisions	• Social withdrawal • Signs of depression, confusion, agitation, shame • Difficulty scheduling time to visit with flimsy/minimal explanation • Mocking or derisive communication from perpetrator in front of others • Unusual passivity or aggression
Physical	• Punching, kicking, slapping etc (with or without use of weapons) • Inappropriate use of physical or chemical restraints • Overmedicating or undermedicating • Locking a person in a room/home	• Physical injuries not consistent with stated mechanisms; repeat presentations for injuries* • Sudden changes in mental state or medical conditions that cannot be otherwise accounted for • Not requiring scripts for regular medications when they are due • Multiple fractures
Sexual	• Inappropriate and/or unwanted sexual advances or contact • Sexual assault • Enforced nudity in front of others	• Unexplained vaginal bleeding (carefully exclude other medical causes) • Signs of depression or fear towards a particular person • Unexplained sexually transmissible infection or incontinence • Breast or genital injury
Financial	• Forced selling of assets • Use of bank accounts without consent • Selling possessions or changing will against their wishes • Abusing power of attorney	• Unpaid bills; new debts • Unexplained disappearance of belongings • Significant bank withdrawals or changes to will • Empty fridge; weight loss • Recent addition of a signature to a bank account
Neglect	• Withholding of food, water, medications • Inadequate clothing, hygiene, bedding • Exposure to unsafe or unsanitary living conditions • Refusal to allow other people or services to provide care	• Complaints of being too hot/too cold; inadequate/inappropriate clothing • Sudden deterioration in personal hygiene • Medical conditions not being reviewed/managed • Unexplained weight loss • Delirium, confusion, dehydration, acute renal failure • Carer may appear overly attentive in the presence of others

*Significant bruising can occur in patients who are elderly or frail even with relatively minor trauma, as a result of skin and vessel fragility. Other causes to be considered include medications (anticoagulants, corticosteroids) and medical causes (liver disease, end-stage kidney disease, thrombocytopenia, chronic alcohol abuse).

Adapted from Ageing & Disability Commission, What is abuse and neglect?, Sydney, NSW: NSW Government, 2020, Available at www.ageingdisabilitycommission.nsw.gov.au/tools-and-resources/for-the-community/what-is-abuse-and-neglect [Accessed 23 November 2020].

son places him at significant risk of further injury and even death may be appropriate, and referral to local crisis accommodation services might be appropriate. If Tom chooses to remain living with his son, discussing a safety plan for future situations and following up regularly with Tom may help avert poor outcomes in the future. If possible, providing Tom's son with services and support to wean off methamphetamine might also have a positive effect on Tom's safety.

Local services that may offer assistance vary significantly between states and territories.

Where to get help

Contact numbers for Relationships Australia's Elder Relationship Services are listed in Table 2.[5]

Table 2. Contact numbers for Relationships Australia's Elder Relationship Services

State/territory/region	Telephone number
Canberra region and Wagga Wagga	1300 364 277
NSW	Services coming soon
NT	1300 364 277
Qld	1300 063 232
SA	(08) 8223 4566
Tas	1300 364 277
Vic	1300 364 277
WA	(08) 6164 0171

You can also contact the state and territory information and assistance services listed in Table 3.

Table 3. State and territory information and assistance services[5]

State	Providers	Telephone number
ACT	Older Persons Abuse Prevention Referral Line	(02) 6205 3535
NSW	NSW Elder Abuse Helpline	1800 628 221
NT	Elder Abuse Information Line	1800 037 072
Qld	Elder Abuse Prevention Unit	1300 651 192
SA	Aged Rights Advocacy Service Elder Abuse phoneline	(08) 8232 5377 1800 372 310
Tas	Tasmanian Elder Abuse Helpline	1800 441 169
Vic	Seniors Rights Victoria	1300 368 821
WA	Elder Abuse Helpline	1300 724 679

Answer 4

Ensure that you have received consent from Tom to provide a statement to the police. Receipt of a subpoena for medical records does not authorise a general practitioner to provide a statement to the police. It is appropriate to call your medical defence organisation and seek advice, especially if you are not comfortable writing a report. It may be possible for the police to use the patient's existing medical records to request an expert opinion from a forensic physician.

Lifeline provides support and referrals for those in crisis 24 hours a day, seven days per week. Lifeline can be contacted on 131 114 or accessed online (www.lifeline.org.au).

If you choose to write a police report, consider including the following:

- your qualifications and experience
- a brief, relevant summary of how you came to see the patient, and what they told you
- a list of your objective examination findings, including any limitations to your examination (eg parts of body not examined, whether there was poor lighting)
- a description of any investigations or management you recommended for the patient
- an explanation of all medical terms and concepts required for a non–medically trained person to understand the content of the report. This may help minimise the likelihood of being called to court to explain the content of your report.

It is also important when writing a medico-legal report to stay within your scope of practice. Avoid the temptation to 'overinterpret' the injuries. You do not need to interpret the injuries at all if it is not something you are comfortable or familiar with. It is important to remain objective and avoid the temptation to 'fit' your findings into the narrative you have been given, and to remain open-minded to alternative possibilities.

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CASE

4 Roberto has died in a nursing home

Roberto, aged 85 years, was a resident of an aged care facility. His past medical history included hypertension and a stroke, and he had recently been diagnosed with type 2 diabetes and chronic lymphocytic leukaemia (CLL). Approximately 20 years ago he underwent an epidural anaesthetic for a minor surgical procedure, which was complicated by a spinal epidural haematoma. This caused an injury to his spinal cord, leaving him with ongoing bladder dysfunction and occasional urinary tract infections. A week ago, you visited Roberto as he became unwell with a fever and complained of pain when passing urine. He was treated with antibiotics, but a day later he started to complain of some loin pain and 'the shakes'. He declined hospital admission. You visited Roberto the next morning and advised the facility team that he had pyelonephritis and was probably septic. An ambulance was called, but Roberto's condition quickly deteriorated. By the time the ambulance arrived, he had died.

Question 1

Is this death reportable to the Coroner?

Question 2

What are the circumstances that require a death to be reported to the Coroner?

Question 3

Why might this death be reportable to the Coroner?

Question 4

Why might this death not be reportable to the Coroner?

Question 5

Under which reportability criteria might Roberto's death be reportable?

Question 6

Is there a requirement to report all deaths resulting from trauma? Does this apply if there has been a significant amount of time since the trauma?

Question 7

How frequently are deaths in Australia reported to Coroners?

Question 8

If you determine that Roberto's death is not reportable to the Coroner, how might you formulate the cause of death?

Question 9

Would you be in a position to complete the Medical Certificate of Cause of Death (MCCD) if you had not previously treated Roberto?

Question 10

To what extent is wording important on an MCCD?

CASE 4 Answers

Answer 1

There is no definite answer to this question because it depends on the interpretation of the treating medical practitioner as to the causal links involved. There are various key issues and factors that can have an impact on the decision to report the death to the Coroner or simply provide an MCCD.

Answer 2

Specific legislation (Coroners Acts) in each state and territory outlines the circumstances in which a death is reportable to the Coroner. Although each state and territory has its own Coroners Act, the criteria for a reportable death are generally similar.

It would be preferable if legislation could definitively provide medical diagnostic clarity about which clinical and circumstantial scenarios demand that the death be reported to the Coroner. However, it is impossible for legislation to be drafted in a way that captures all the nuances of a diagnostic challenge faced by a treating doctor.

In considering whether a death is reportable to a Coroner, there are two main factors to consider. First, does the death encompass a temporal or geographical circumstance that renders the death capable of being reported? This is usually straightforward, and the classes of death able to be reported under these criteria are construed very widely. For a reportable death to qualify as potentially reportable to a Coroner, one of the following must apply:

- the body is in the Coroner's jurisdiction (in the state or territory) or
- the death occurred in the Coroner's jurisdiction (in the state or territory) or
- the cause of death occurred in the Coroner's jurisdiction (in the state or territory) or
- the deceased person normally lived in the Coroner's jurisdiction (in the state or territory) even if they died elsewhere or the cause of their death occurred elsewhere.

Second, if the death meets the criteria of being reportable, it is necessary to consider whether it is reportable given the possible cause of death involved or the circumstances in which the death occurred. Generally, a death will be considered reportable to a Coroner if it falls under at least one of the following categories:

- The death is unexpected.
- The death is unnatural.
- The death is violent.
- The death was the direct or indirect result of an accident.
- The death was the direct or indirect result of an injury (whether recent or acquired previously).
- The death occurred during a medical procedure.
- The death occurred following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.
- The death was of a person who immediately before death was in police, or other lawful, custody or held in care (eg involuntary admission to a healthcare service).
- The death is of a person whose identity is unknown.
- There is no person able to complete/sign an MCCD.

This is quite a long list, but many of these criteria are easy to identify and, if present, the medical practitioner should immediately report the death to the Coroner and refrain from completing the MCCD unless the Coroner's Court, when contacted, indicates that they can.

Answer 3

The critical aspect of determining whether this death should be reported to the Coroner is the assessment of the diagnostic weighting of the competing impacts of Roberto's injury-related bladder dysfunction, his diabetes and his CLL on the development of a fatal sepsis. If your view is that the spinal injury was not directly or indirectly a contributing factor in the development of urosepsis, then the death is entirely due to natural causes and would not be reportable to the Coroner. If you are unsure whether or not the spinal trauma was a contributing factor to the urosepsis, or you believe that the spinal injury was at least in part a contributing factor, then, regardless of how long ago the injury was sustained, the death should be reported to the Coroner.

Answer 4

If you assume that Roberto has died from sepsis due to a urinary tract infection, then his death would be due to natural causes and likely would not be reportable to the Coroner. Roberto has a number of underlying natural diseases (diabetes and CLL) that increase the risks of his developing sepsis as a result of a urinary tract infection.

Answer 5

The reportability criteria that might apply in this case include:

- The death was the direct or indirect result of an accident.
- The death was the direct or indirect result of an injury (whether recent or acquired previously).
- The death occurred following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.

The definition of what is an accident or an injury is usually not further specified in the legislation, and the same applies to the meaning given to 'direct or indirect results' of an accident of injury. In addition, the definition of some of the terms in these reporting criteria can be quite subjective. In relation to medical treatment, some legislation will refer to: 'is or was related to …', 'may be related to …' or 'appears to be …'.

Answer 6

Regarding deaths from violence, accidents or injury, there are some important messages. In particular, there is no requirement that a death needs to be suspicious to make it reportable to a Coroner. Regardless of the circumstances, any death that is directly or indirectly the result of an injury is a death that must be reported to the Coroner. In addition, there is no limit on the time elapsed since the contributing accident

or how old the injury was that indirectly caused the death (eg if an elderly patient with an acquired brain injury from a traffic accident 35 years ago, which left her with swallowing problems, dies of an aspiration pneumonia related to her dysphagia, the death is reportable to the Coroner).

Medical practitioners must consider these issues of reportability each time they complete an MCCD. In doing so, the specific circumstances of a particular patient's death may create an uncertainty in the doctor's mind as to whether reporting to the Coroner is required. In such a situation, general practitioners should contact the state or territory's Coroner's Office and obtain advice regarding whether the Coroner believes the death is reportable.

Answer 7

In the minds of some in the community, the Coroner is thought to undertake either:

- the investigation of all deaths, or
- the investigation of deaths thought to be 'suspicious'.

These views of the role of the Coroner are incorrect. Only approximately 10–15% of all deaths in Australia are reported to Coroners. Of those deaths that are reported to the Coroner, just under 1% involve any allegation of homicide. While approximately 7000 deaths are investigated by the Coroners Court of Victoria each year, fewer than 1% of these proceed to a formal inquest hearing, with the vast majority being concluded by a written 'in chambers' finding.[1]

The vast majority of deaths reported to the Coroner are deaths for which the cause is unknown and/or for which there is no medical practitioner in a position to complete the MCCD. The majority of the deaths that are reported to the Coroner are people found to have died of natural causes, and today in some jurisdictions fewer than half of the reported deaths require or are subject to an internal examination or dissection-based autopsy.[1]

Studies have shown that the under-reporting of deaths to the Coroner from major public hospitals ranges from 10% to 30% of deaths.[2] Seven hundred deaths per year in Victoria are reported to the Coroner by the Registrar of Births, Deaths and Marriages because the cause of death or other information on the MCCD provided by the medical practitioner would suggest the death should have been reported. These are concerning figures. The failure to report a death to the Coroner carries penalties,[3] and these, as well as the procedural irregularities associated with the death certificate, raise the prospect of the medical practitioner's conduct being investigated by the regulator.

Answer 8

The international form of MCCDs set out by the World Health Organization is used by most jurisdictions worldwide.[4] An example is shown in Figure 1.[5]

One of the most important principles in completing the causes of death sections for the MCCD is the 'keep it simple' or KISS principle. Medical practitioners who try to overly complicate cause of death statements may become involved

International Medical Certificate of Causes of Death

Part I	Cause of death	Approximate interval between onset and death
*Disease or condition directly leading to death**	(a) _____ due to (or as a consequence of)	_____
	(b) _____ due to (or as a consequence of)	_____
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(c) _____ due to (or as a consequence of)	_____
	(d) _____ due to (or as a consequence of)	_____
Part II		
Other significant conditions contributing to the death, but not related to the disease or condition causing it. *This means the disease, injury or complication which caused the death, NOT ONLY, for example, the mode of dying such as 'heart failure, asthenia' etc.	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Figure 1. International Medical Certificate of Causes of Death[5]

Reproduced with permission of The Royal Australian College of General Practitioners from Bird S, How to complete a death certificate – A guide for GPs, Aust Fam Physician 2011;40(6):446–49.

in a complex 'linked causation' analysis that does not add value either for the family or the state's health statistics. It would be possible in this case to simply list 'urosepsis' in Part 1(a) as a true, rational and clear determination of what caused Roberto's death. However, this would not be particularly transparent as to do so would limit the understanding of the significance of his diabetes or immunosuppressive disease entities in contributing to urosepsis.

This raises the issue of causation linkage in the fields 1(a) due to 1(b) due to … (and so on). In this case, it is not possible to put CLL into the 1(b) field and diabetes into the 1(c) field, or vice versa, as they are independent entities without a causal linkage. However, it is possible to consider them both to be important natural disease processes that led to urosepsis. Unfortunately, since the format of the MCCD fields does not allow for multiple but independent pathways to a single cause of death, it is often necessary to list more than one disease in the fields for 1(b) or 1(c). This can cause difficulties for data collection in health statistics, but it may be the only way of expressing the causation pathways. An alternative approach is to use Part 2 of the cause of death statement, which does allow for a separate pathway when there are two immediate causes of death, but a disease listed in Part 2 cannot be related to the causes in Part 1.

Another very important issue to consider is that, if you have decided that the spinal injury has not contributed to the death (so that it is not reportable to the Coroner), then that information should not appear anywhere in the certificate. Part 2 of the cause of death fields in an MCCD is still part of the conditions that contributed to the death and therefore part of the cause of death for the purpose of deciding whether a death is reportable to the Coroner. If the injury is included in any of the cause of death fields in the MCCD, then the death certificate would likely be rejected, and the death reported to the Coroner by the Registrar of Births, Deaths and Marriages.

Returning to the 'KISS' principle, it is important to focus the cause of death statement on disease entities that are relevant to the actual death and to not include diseases or conditions that did not cause the death.

The key principle here is that the MCCD is a document outlining the cause of death. It is not a 'comorbidity' certificate. Similarly, the certificate should not be an executive synopsis of a patient's discharge summary or their medical history. A particular disease, disability or medical conditions may have been highly significant factors in a patient's medical history and have limited a patient's lifestyle and quality of life, yet these need not have been factors in their death. If that is the case, these factors should not be listed on the death certificate as being part of the patient's cause of death.

For further general information on the certification of causes of death in Australia, refer to the information paper produced by the Australian Bureau of Statistics titled *Cause of Death Certification, Australia*.[6]

Answer 9

Even if Roberto were not your patient, you are permitted to complete the MCCD if you have enough information to do so. You must determine how much information is sufficient. The quantum and depth of the information you require will depend on the particular factors in each case. To acquire sufficient information, you will usually be required to examine the deceased and undertake a retrospective review of the patient's medical records. There is no reason not to make use of the information that family or friends may be able to supply regarding the recent history and circumstances of the death, but you should be careful not to give this information the same weight or probative value that you would give a health practitioner's records, or medical records such as recent pathology or radiology test results or hospital specialists' letters.

Answer 10

When formulating the cause of death, it is important to be very careful when using phrases that could be interpreted by administrative staff within the office of the Registrar of Births, Deaths and Marriages as referring to an accident or injury. They may assume that the death needs to be reported to the Coroner.

For example, 'acquired brain injury' can be the result of blunt or accelerative force head trauma, an illicit drug overdose, atherosclerosis-related cerebral infarction or a cardiac arrest related to ischaemic heart disease; the latter two conditions are natural disease processes that do not make the death reportable. Another such term is 'cerebrovascular accident' because, although this is clearly a medical description of a natural disease process, the administrative staff may interpret this as referring to an accident. If the certifying doctor believes that the death is solely the result of a natural disease process, words such as 'fall' or 'collapse' should be avoided in the formulation of the cause of death as these words may lead others to conclude that the death should have been reported to the Coroner.

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CASE

5 Kabir has lost his licence

Kabir, aged 75 years, is a retired accountant who presents to you following suspension of his car licence by the licensing authority. He is accompanied by his wife, Jasleen. You have been Kabir's general practitioner (GP) for two decades. Other than bilateral cataract surgery three years ago and essential hypertension, which is well managed with hypotensive medication, his medical history is unremarkable.

Kabir is irate and tells you that police had reported him to the licensing authority after he got lost driving home at night two months ago. He is annoyed and does not understand what the fuss is all about. He tells you that, other than a collision when he was aged in his 40s, which was not his fault, and a couple of speeding fines, he has a good driving record. He tells you that the loss of his licence has negatively affected his independence and curtailed his activities.

Question 1

Why is fitness to drive an important medical issue?

Further information

Jasleen has remained silent throughout the initial consultation, but now hesitantly tells you that she has been concerned about her husband's driving for the past six months. She reveals that this is not the first time that he had got lost driving recently. She tells you police located him 20 km from home sitting in his car, confused. She says that Kabir became angry and defensive after she asked him about multiple unexplained scrapes and minor dents on his car.

Kabir berates Jasleen. He says there are no issues with his driving and that she should mind her own business. He asks you to complete a licensing authority medical form so that he can resume driving and apologises for wasting your time.

Question 2

Should Kabir have reported these events to the licensing authority?

Question 3

How would you assess Kabir?

Further information

You take a history from Kabir and do an examination including a Montreal Cognitive Assessment (MoCA). You suspect that Kabir has mild cognitive impairment (MCI) or mild dementia. You find that his corrected binocular visual acuity is 6/12; his visual field is full to confrontation; his blood pressure is reasonably controlled; the tone, power, movement and sensation in his upper and lower limbs, and gait, are normal; his mental state is unremarkable; and his MoCA is borderline abnormal for his age and level of education.

Question 4

What will you recommend to the licensing authority in terms of Kabir's fitness to drive?

Further information

Kabir impatiently listens to your recommendation for him to undergo an occupational therapy driving assessment. He tells you that he is disappointed in you and that he wishes he had gone somewhere else to have his form completed. He tells you that he cannot afford an occupational therapy driving assessment but would settle for a standard driving test administered by the licensing authority, which he says he would pass with flying colours.

Question 5

What are some of the challenges in assessing fitness to drive in the general practice setting?

Question 6

Are you ultimately responsible for determining Kabir's fitness to drive?

CASE 5 Answers

Answer 1

Practitioners can access the key source document used in this field: *Assessing Fitness to Drive* (available as a hard copy or online at https://austroads.com.au/__data/assets/pdf_file/0022/104197/AP-G56-17_Assessing_fitness_to_drive_2016_amended_Aug2017.pdf).[1]

Public health and safety

Traffic crashes are the greatest cause of preventable death and injury. For every death there are many injured and disabled individuals with lifelong implications.[2]

The social and economic significance of driving has health implications for the person unable to drive. Fitness to drive determines earning potential (eg commercial drivers), lifestyle and access to services for an individual.

It is not uncommon for individuals to become depressed following licence cancellation.[3] For elderly people, there is also some suggestion that it hastens placement into residential care.[4]

Medico-legal implications

Police investigating collisions will seek opinions on whether a medical condition could have been a factor, to determine culpability and/or responsibility and/or liability of drivers.[1]

For this purpose, they can subpoena medical notes from a variety of sources (hospital, GP and licensing authorities) seeking answers to questions such as:

- Is there a medical condition that could affect driving or that warranted notification to licensing authorities?
- If so, is there discussion of fitness to drive anywhere in the notes?
- If so, was the advice in keeping with current guidelines?
- Was the advice followed by the patient?
- If no discussion about driving was recorded, did the condition(s) warrant a discussion with the patient?
- Were licensing authorities aware of the condition?

Answer 2

In all states and territories, it is compulsory for drivers to report medical conditions that are temporary, progressive or permanent and may affect driving ability.[1]

Recurrent issues with self-reporting include the following:

- Many drivers are unaware of their legal obligation to self-report.
- Some people view their condition as minor.
- People may argue that their doctors did not inform them to self-report.
- People may mistakenly believe that it is the role of their doctors to report.
- Many people are worried about losing their licence.
- Some people lack insight; this is particularly relevant to conditions like mental disorders, dementia or substance abuse.

Answer 3

The history provided raises concerns about Kabir's cognitive functioning, and this warrants formal assessment. Additionally, a physical examination targeting his physical functioning pertinent to driving is also warranted.

Answer 4

It is generally accepted that dementia can affect cognitive functions involved in driving such as visuo-spatial skills, attention, processing speed and judgement. Cognitive and functional decline are generally clear enough in people with moderate and severe dementia to exclude driving. The requirement for assessing fitness to drive therefore tends to focus on those with mild dementia and MCI.[1]

While bedside cognitive testing alone can identify individuals with MCI and mild dementia, this does not correlate with driving competence for several reasons. People with MCI generally exhibit a similar range of driving ability to those with normal cognition. In people with mild dementia, learnt skills are relatively well preserved; instead, it is adaptation to new situations that is often impaired.[5] In such instances, an occupational therapy driving assessment is considered the 'gold standard' and should be recommended.

A licensing authority driving test is inexpensive (free in some states and territories), easy to arrange and useful for 'bad' drivers. However, it lacks the rigour of an occupational therapy driving assessment, and testers have no clinical insight into the conditions of those tested.

An occupational therapy driving assessment is expensive and scarce. It includes off-road and on-road components. It is useful for acquired disabilities or progressive conditions. It does not test likely reaction in an emergency or predict future crash risk.

Answer 5

There is variable interest among GPs to undertake assessments for fitness to drive.[6] Common reasons given include:

- a perceived detrimental effect on the doctor–patient relationship and negative impact on continuity of care
- many conditions that affect driving rely on honesty between patients and doctors (eg reporting seizures in people with epilepsy or hypoglycaemic episodes in people with diabetes)
- reluctance to get involved in notification and medico-legal issues
- inadequate experience or training in doing fitness to drive assessment
- time constraints – how does a busy GP assess fitness to drive in <15 minutes?
- being blinded to the reason for the patient's request
- being unfamiliar with the patient's history (eg a new patient).

Answer 6

No. The ultimate decision regarding fitness to drive lies with the licensing authority. However, to reach a decision, the licensing authority relies on multiple sources of information that can include the drivers themselves; families, neighbours, workmates and anonymous individuals; healthcare professionals; police, occupational therapy driver assessors and, in some instances, external medical advisors.

The decision to inform the licensing authority rests with the assessing medical practitioner in all Australian states and territories except South Australia and the Northern Territory, where practitioners are legally obliged to report patients who they believe are unfit to drive.[1] In all Australian states and territories except the Northern Territory, reports made in good faith but without the patient's consent are protected from legal liability.[1] While the ultimate decision on fitness to drive rests with the licensing authority, best practice recommends that you should document your discussion with and advice to your patients, as well as their response, in your clinical records.

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ACTIVITY ID **228501**

Medico-legal

This unit of *check* is approved for six CPD Activity points in the RACGP CPD Program. The expected time to complete this activity is three hours and consists of:

- reading and completing the questions for each case study
  - you can do this on hard copy or by logging on to the RACGP website (www.racgp.org.au), clicking on the My Account button and selecting the *gplearning 2020* link from the drop-down
- answering the following multiple choice questions (MCQs) by logging on to the RACGP website (www.racgp.org.au), clicking on the My Account button and selecting the *gplearning 2020* link from the drop-down
  - you must score ≥80% before you can mark the activity as 'Complete'
- completing the online evaluation form.

You can only qualify for CPD points by completing the MCQs online; we cannot process hard copy answers.

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Case 1 – Khanh

Khanh is a medical student undertaking a rotation at your practice. He is interested in expanding his knowledge of legal issues relevant to general practice, specifically regarding reporting to the Coroner following a patient's death. You consider your knowledge in this area of practice to advise Khanh.

Question 1

Regarding deaths from violence, including accidents and injury, which one of the following statements is false?

A. The death needs to be suspicious to make it reportable to the Coroner.

B. Any death that is directly or indirectly the result of an injury must be reported to the Coroner.

C. There is no time limit regarding how long ago the contributing accident was or how old the injury was that indirectly caused the death.

D. Failure to report a death to the Coroner carries penalties.

Question 2

Which one of the following cases would **not** be considered reportable to the Coroner?

A. A previously healthy child, aged three months, was found dead in her cot.

B. A man, aged 80 years, with a long history of ischaemic heart disease collapsed and died while walking.

C. A man, aged 97 years, being treated for pneumonia, died three weeks after a surgical intervention for a fractured hip.

D. A student, aged 22 years, who recently returned from Africa presented with headache, photophobia and neck stiffness. Acid-fast bacilli were seen in the cerebrospinal fluid smears. Despite aggressive treatment, she developed persistent seizures and died.

Case 2 – Carole

Carole, aged 33 years, presents to your practice for the first time. She discloses to you that she is fearful of the behaviour of her partner.

Question 3

Which one of the following single features of Carole's history would make you **most** concerned about her safety in regard to the risk of homicide?

A. Her partner has been verbally abusive towards her.

B. Her partner has access to weapons.

C. Her partner has strangled her and she lost consciousness.

D. Her partner frequently searches her mobile phone and arrives unexpectedly at her workplace.

Case 3 – Marina

Marina, aged 17 years, presents with her mother, Tamika. Her mother informs you that she found Marina partially undressed in her bedroom with her boyfriend, aged 19 years. Tamika demands that you examine Marina and then inform the police that her daughter has been sexually assaulted.

Question 4

Which one of the following constitutes child sexual abuse?

A. Consensual sexual activity between a person aged 14 years and a person aged 15 years

B. The viewing of sexual images by a person aged 17 years and a person aged 19 years

C. Consensual sexual activity between a person aged 14 years and a person aged 22 years

D. Sexual activity between two people with Down syndrome aged 15 years

Case 4 – Renata

Renata, aged 20 years, presents to you after a male she met at a party the night before strangled her during sexual intercourse that was initially consensual. She appears teary and says she cannot recall details of the incident, although it is difficult to understand her because her voice is hoarse and very quiet. She has no visible injuries to her neck or face. She thinks she must have had her drink spiked as she awoke having lost control of her bladder.

Question 5

Which one of the following features of Renata's presentation can occur in people who have been strangled?

A. Difficulty swallowing

B. Hoarse voice

C. Absence of external neck injuries

D. All of the above

Case 5 – Sunny

A police member attends your practice and requests the medical file of Sunny, a female patient aged 31 years, who is a regular patient of yours. Sunny has provided a statement to police regarding historic family violence matters, including strangulation. She has since ceased cooperating with police and has returned to live with her partner.

Question 6

Under what circumstances would you provide the police with Sunny's medical file?

A. The provision of a court order or written consent from the patient

B. A request for the release of Sunny's medical records to police, signed by the patient's mother

C. A telephone call from the patient's lawyer stating Sunny advised she is happy for her medical records to be released to the police

D. Written correspondence from your patient's social worker stating Sunny is vulnerable and being coerced by her partner to stop cooperating with police

Case 6 – Yahir

Yahir, aged 20 years, presents after being involved in an altercation with two other men. He reports that one of them was carrying a metallic object but was not able to identify what type of weapon it was. Yahir experienced severe pain and bleeding from his arm and other sites during the assault and requires treatment.

Question 7

How would you describe the injury shown in Figure 1?

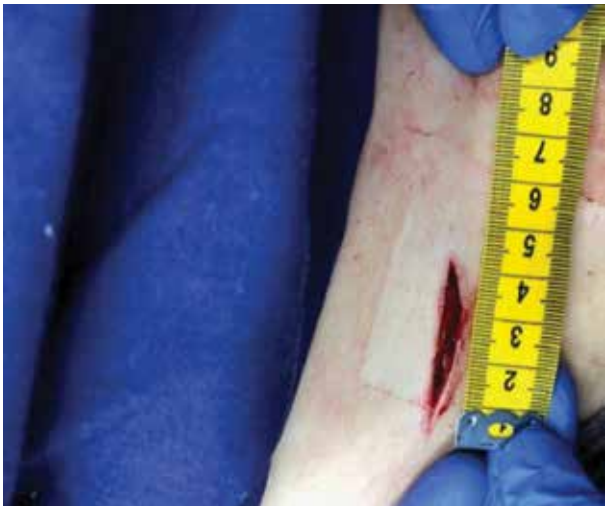

Figure 1. An injury of unknown cause

A. A laceration from a sharp object, as the edges are well defined

B. A laceration from a blunt object, as the wound is gaping

C. An incision from a sharp object, as the edges are well defined

D. A incision from a blunt object, as the edges are not well defined

Further information

Several months later, you receive a request from police for a medical report regarding your assessment of Yahir.

Question 8

Which one of the following statements is correct regarding injuries?

A. Attempted strangulation is almost invariably associated with visible injuries to the neck.

B. It is possible to age injuries with a high degree of certainty.

C. The terms 'cut' and 'laceration' can be used interchangeably because they have the same meaning.

D. There are a number of medications and conditions that are associated with an increased propensity to bruising.

Case 7 – Emilio

Emilio, aged 40 years, is a labourer who presents after having a series of blackouts in the previous weeks. His history includes chronic heavy alcohol consumption and regular use of marijuana and possibly other illicit substances. You inform him that he should not drive until the cause of the blackouts has been identified and treated. Emilio tells you that his license is essential to his employment and declines to undertake the investigations.

Question 9

Given Emilio's response, which one of the following actions should you initiate?

A. None – Emilio has the right to accept or reject your advice

B. Inform Emilio's employer that he should not drive a company vehicle

C. Telephone Emilio's wife and seek her assistance to have him comply

D. Inform the driving licensing authority of the situation

Question 10

Regarding driving and fitness to drive, which one of the following statements is correct?

A. The same medical standards apply for all types of vehicle licenses.

B. Most conditions causing a sudden loss of consciousness warrant a driving assessment from an occupational therapist.

C. Medical practitioners are the final arbiters on decisions to issue a license and suitability to drive.

D. Many conditions that affect driving rely on honesty between patients and doctors.

check

Independent learning program for GPs