Caring for patients reporting assault

With increased reporting of domestic violence in New Zealand, it is timely to consider GPs' responsibilities when caring for patients reporting assault. Such patients raise complex issues for GPs, particularly when working under tight time and resource constraints in an after-hours setting. A complaint to HDC earlier this year highlights the general principles that apply to the assessment and treatment of patients reporting assault.

Mrs A's experience

On 29 December 2007, Mr and Mrs A had an argument about the use of the dishwasher. Their conflict escalated. Mr A knocked Mrs A to the ground and attempted to strangle her with a tea towel. After several seconds, he let go of the tea towel and Mrs A ran to her friend's house where she called the Police. Constable B received Mrs A's formal complaint of assault and advised her to see a doctor for treatment and documentation of her injuries.

Later that day, Mrs A presented to the local after-hours clinic with her friend. The receptionist initially told Mrs A that she could not see the doctor because she was not registered with any of the contributing clinics. But after hearing about the assault, the receptionist spoke to the sole on-duty doctor, Dr Y. Without assessing Mrs A herself, Dr Y relied on the information provided by the receptionist and declined to see Mrs A. Dr Y understood that Mrs A did not need urgent medical attention and was mindful that "evidential examinations are usually very time consuming". Dr Y also understood that the receptionist had referred Mrs A to the other after-hours clinic in the region. According to Mrs A and her friend, they were told the doctor would not see Mrs A because she did not want to attend court at a later date. Dr Y denied that this was her reasoning.

Mrs A and her friend then presented to the second after-hours clinic, nearly 20 km away, only to receive a similar response. Mrs A was initially informed that the sole on-duty doctor, Dr Z, would not see her because he did not wish to be called to give evidence in court. This time, Mrs A's friend held her ground. Eventually Dr Z spoke with Constable B over the phone, emphasising his reluctance to get involved in a domestic violence prosecution or to lose a day giving evidence in court. However, at Constable B's insistence, Dr Z reluctantly agreed to see Mrs A.

Complaint

Constable B was concerned about Mrs A's experience at the two after-hours clinics and she complained to HDC in February 2008. Mrs A was described as a "very quiet woman who would never make a scene or assert herself in these circumstances". Constable B commented:

"Victims of domestic assault are not usually gifted with large amounts of self confidence. The courage it takes to report an assault of this kind to the Police is considerable. Facing the prospect of further disclosure to a doctor unknown to the victim further taxes any slim reserves of nerve. To then be turned away from not just one but two after-hours clinics is enough to make such a victim give up."

Both doctors strongly refuted the allegation that they had breached their duty of care by turning away Mrs A. In their defence, they cited the desperate shortage of doctors in the area, particularly for after-hours care.

Expert advice

There were clearly some tricky issues in this case. I sought expert advice from Dr Clare Healy, a GP with a special interest in domestic violence, and Dr Stuart Tiller, my in-house clinical advisor.

GP skills in responding to assault injuries

Dr Healy and Dr Tiller differed on the responsibility of a GP to treat patients reporting assault. Dr Healy advised that forensic expertise is not within the traditional skill set of GPs. She said that in view of the current training and availability of GPs, particularly in after-hours situations, the expertise required for assault assessments would be better found within the Police Medical Officer workforce or Emergency Department specialists.

In contrast, Dr Tiller advised that, while it is not appropriate for any doctor other than one trained in the correct techniques of forensic examination to examine a victim of sexual assault, most other assault injuries can be examined and documented in primary care.

I accepted Dr Tiller's view that there may be some situations where a GP can treat a patient reporting assault. Even if the doctor does not specifically provide treatment, there may still be a responsibility to appropriately assess and refer such patients.

Duty to treat

Right 4(2) of the Code of Patients' Rights affirms the obligation to provide medical services that comply with the New Zealand Medical Association Code of Ethics (2002) and the Medical Council's statement "A doctor's duty to help in a medical emergency" (2006).

The NZMA Code of Ethics states that doctors "have a right, except in an emergency, to refuse to care for a particular patient". The Medical Council warns that a "doctor is at risk of being professionally or criminally responsible if he or she fails to render prompt and appropriate medical care to any person (whether the patient is a current patient or not), in a medical emergency". Accordingly, a doctor must see patients who present in an emergency situation or who are in need of urgent care.

In this case, Dr Y relied on the advice of her receptionist that Mrs A did not require emergency treatment. In Dr Z's view, Mrs A's situation "was clearly not an emergency or urgent", and he "was under no obligation whatsoever to see her". However, Dr Tiller noted that a medical emergency could potentially have a broader definition:

"It is my view that any assault that threatens life, such as an attempted strangulation, constitutes a medical emergency, on the grounds of possible physical injury and/or the threat to the psychological health of the victim/patient. Some such victims will have

suffered previous emotional ill health and the acute event may be anticipated to trigger a more severe psychological reaction.

It is for this reason that the apparent lack of distress exhibited by [Mrs A] is not, in my view, sufficient reason to determine that she did not require urgent medical assessment and could wait till after the weekend to consult her usual general practitioner."

Triage
Both experts noted that patients reporting domestic violence should be assessed to determine the extent of their injuries, if any. Dr Healy advised that this initial assessment does not necessarily need to be undertaken by a doctor. But Dr Tiller considered that the assessment should be undertaken by a suitably qualified person:

"It is my view that assessment of urgency or severity should not be a function of the receptionist role. This is a nursing responsibility and the receptionist should have a low threshold for informing the nurse of patients presenting and waiting, the nature of their problem, or any concerns [he or] she holds regarding patient demeanour or behaviour in the waiting room."

Appropriate referral
Both experts advised that if a GP is unable to provide the necessary clinical care, either through resource constraints or limits to their scope of practice, the GP should acknowledge this to the patient and actively arrange care from an alternative provider. This may require the doctor to make enquiries and communicate with other providers to ensure the patient receives the ongoing care he or she needs. Dr Tiller noted:

"A GP's role is to help patients 'access the system'. If the GP felt out of his/her depth clinically they should acknowledge that to the patient and phone to ensure they source a provider who can meet the ongoing clinical needs of the patient."

Dr Healy agreed that a GP should "explain that the examination and accurate documentation of possible injuries might take some time. An offer could then be made for the patient to wait until time became available or alternatively that attending a person with more expertise [such as an ED doctor] would be more appropriate."

Dr Tiller further advised that, even if a patient is referred to another provider, a GP "should make some effort to address the emotional state and needs of such a patient".

Conclusion
I took an educational approach to resolving this case. Although I did not proceed to a formal investigation, I highlighted the lessons from the complaint to Drs Y and Z.

At some point, all GPs are likely to encounter a patient who presents reporting assault. Your ability to respond will be constrained by time and experience. However, in my view patients are (as a minimum) entitled to expect:

- an empathic and sensitive response

- an initial triage assessment by a doctor or another suitably qualified person to determine the extent of their injuries, both physical and psychological
- emergency treatment, where appropriate
- information about the options for forensic documentation of the injuries, either by the GP or by an expert in the area, and
- a referral or assistance in contacting other suitably qualified providers and agencies such as ACC.

It can be very difficult for victims of domestic violence to seek medical help. Providing basic care and information is the humane and professional response that most GPs would seek to offer, and is consistent with a doctor's ethical and legal obligation.

Ron Paterson*
Health and Disability Commissioner

New Zealand Doctor, 3 December 2008

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