

LETTERS TO THE EDITOR

Teaching medical students about violence

To the Editor: Violence in Australian society is a matter of current national concern.¹ Violence means family violence in the vast majority of cases with so far unmeasured health costs to the community. The Australian Medical Association, through its President's Advisory Group on Women in Medicine, investigated the current level of adequacy of coverage of this topic in the curricula of Australian medical schools.

A questionnaire about domestic violence was circulated to all deans of the ten medical faculties in Australia. Information was sought about whether child abuse, spouse abuse, sexual abuse (child and adult) and elder abuse were covered in the existing curricula, with details as to timing, form and departmental responsibility. Comment was invited on possible change.

All medical schools completed the questionnaire. The current situation is summarised below.

Child abuse and child sexual abuse are covered by all medical schools. Coverage is extensive with time allocation varying from 1 to 21.5 hours for child abuse, and 1 to 14 hours for child sexual abuse. Coverage is primarily in second and third years, but also in clinical years by departments of psychiatry, paediatrics and virology, and in human sexuality courses. A range of lectures, seminars, tutorials, ad-hoc clinical teaching, and some assignments, special placements or electives exists.

Spouse abuse does not attract the same concern. Three universities had no known specific reference to spouse abuse. The topic is referred to by others at various times throughout the preclinical and clinical years for fewer than three hours. One university provided one lecture and another a part of one lecture. Three used seminars, tutorials and ad-hoc teaching from departments of psychiatry, community medicine or behavioural science and medicine.

Adult sexual abuse was much less well covered with five universities apparently making no reference to this topic. Others indicated an allotment of up to three hours, though most gave much less in either preclinical or clinical years.

Elder abuse received even less recognition. Six universities made no reference at all: four believed it was referred to in ad-hoc teaching and assignments, with one occasional seminar.

Most responses indicated receptivity to the enquiry and interest in the issues. Several indicated that domestic violence and adult sexual assault would be included in reviews. The topic of elder abuse appeared less well recognised, but again there was a willingness to consider, with a realisation that the issue would become more significant in an ageing population.

Only one faculty seemed to indicate that the enquiry represented yet another impossible intrusion into an already overcrowded curriculum.

The training of medical students is under considerable discussion and review at the present time, with a number of universities contemplating significant reorganisation and change in training doctors for the 21st Century. These changes are stimulated, not only by the explosion in medical knowledge which threatens to make existing curricula unmanageable, but also by a growing awareness of the need for relevance if the basically trained medical practitioner is to be an appropriate health service provider in modern Australian society — one who is alert and sensitive to its particular psychosocial, as well as physical, health needs. In this context, increased training in the early identification, intervention, assessment, and management of family violence and sexual violence will be necessary. While it may be construed that the current levels of training are inadequate, there is promise that, with greater awareness, there will be increased

attention paid to a significant public health problem in modern Australian society.

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Can infant death from child abuse be prevented?

To the Editor: The eminent group of pathologists who wrote¹ in response to our recent publication² quite rightly pointed out that the diagnosis of sudden infant death syndrome (SIDS) is a pathological one; that is, a sudden unexpected death in an infant for whom adequate at-the-scene investigation and autopsy fail to identify a cause of death.

However, they have not taken note of the messages included in our article that: (i) adequate death scene investigation is often not carried out; and (ii) appropriate autopsy is not always performed particularly in this large State (Queensland) where a diversity of practitioners are asked to perform autopsies.

Even when adequate death scene investigation and autopsy are carried out there will still be a small group of infants who will have died due to "gentle smothering" who will be labelled as SIDS deaths. Only thorough investigation of the social as well as the medical history will highlight the likelihood of this occurrence and allow appropriate interventions for subsequent children who will be at risk of similar death.

Although we were prevented from releasing the details of each case in our article, it is a fact that in most of the infants the final registered cause of death was SIDS, even when there were significant autopsy findings other than those consistent with SIDS. Thus it is likely that there is an overestimate of SIDS deaths and an underestimate of deaths due to child abuse in the recorded figures of deaths in Queensland, however small this difference may be.

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1. Cooke CT, Cadden GA, Margolius K, et al. Can infant death from child abuse be prevented? [letter]. *Med J Aust* 1991; 155: 851-852.
2. Armstrong KL, Wood D. Can infant death from child abuse be prevented? *Med J Aust* 1991; 155: 593-596.

An epidemiological study of snake bite envenomation in Papua New Guinea

To the Editor: Despite Campbell's classic descriptions of the clinical features and management of Australasian elapid snake bite in the 1960s¹ there remain many secrets of the Papuan snake fauna. Dr Trevett and Dr Laloo² provide further important information.

In the 1960s the Papuan black snake (*Pseudechis papuanus*) was common enough to provide the black snake (*Pseudechis* genus) antivenom in the Australia-New Guinea polyvalent antivenom. Subsequently it had to be replaced by king brown snake (*Pseudechis australis*) antivenom, which is in the current polyvalent antivenom. The intriguing questions are: What are the clinical effects of envenomation from the Papuan black snake, and where are such cases occurring? Campbell

noted that results of his laboratory work with Papuan black snake venom were at variance with the previous clinical observations of bites attributed to that snake.³ In particular, there was no in-vitro or animal in-vivo evidence of defibrination from procoagulant activity. There was, however, a strong anticoagulant effect in addition to the known haemolytic action.⁴ This venom appeared therefore similar within the *Pseudechis* genus to that of the king brown snake in being haemolytic and anticoagulant, but different from red-bellied black snake (*Pseudechis porphyriacus*) venom which is haemolytic but procoagulant.^{4,5}

The uncertainty about the clinical effects of Papuan black snake venom increases when one considers neurotoxicity and myotoxicity. The king brown snake can cause severe myotoxicity with rhabdomyolysis, but true neuromuscular paralysis has been thought not to occur.⁶ At Royal Darwin Hospital we recently treated a confirmed king brown snake bite with severe myotoxicity but also with classical moderate neurotoxic paralysis (ptosis and ophthalmoplegia).

Regarding the Veifa'a and Bereina area (Kairuku district) of Central Province, where the two Papuan black snakes were found, additional unpublished data from our earlier 30 month prospective study beginning January 1987⁷ are as follows:

- Seventeen envenomed patients from this area were admitted to Port Moresby General Hospital. Ten bites (four patients ventilated) were confirmed by venom immunoassay as Papuan taipan bites (*Oxyuranus scutellatus canni*); one (patient ventilated) was confirmed as death adder (*Acanthophis antarcticus*); and six (one patient ventilated) were of unconfirmed species. None was positive by venom immunoassay for Papuan black snake.
- Six of 104 (5.8%) envenomed patients treated at Veifa'a Health Centre died. This is similar to the 6.3% mortality at Port Moresby General Hospital during the study period, but it should be noted that ventilation is not usually possible at the Health Centre even if it is thought necessary.

These data are not inconsistent with the suggested clinical predominance of the Papuan taipan throughout Central Province as well as in the National Capital District,⁸ but they support the need for further study.

In addition to the Papuan black snake the significance and clinical syndromes of the Papuan whip snake (*Demansia papuensis*), the small-eyed snake (*Micropechis ikaheka*) and the brown snake (*Pseudonaja* sp.), recently confirmed in Central Province by venom immunoassay, all need clarification. Results of the prospective study by Dr Trevett and Dr Laloo, utilising immunoassays developed at the Liverpool School of Tropical Medicine and Hygiene by Dr R D G Theakston, are likely to have major implications for our understanding of Australasian snake bite and its management.

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