

Australian Medicine in Context



Key presentations and topics
for entry to practice

'The purpose of the Australian Medical Council is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.'

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Acknowledgement of Country

There is not a part of Australia, nor of her Peoples, that has not been loved and nourished and cared for since the beginning of time ...

We pay our respects to all Aboriginal and Torres Strait Islander Elders, their families and their communities, and thank them for allowing us to do the work we do on these sovereign lands.

We recognise the continuing connection of Aboriginal and Torres Strait Islander peoples to the skies, lands, waters and innumerable cultures and languages. We pay our respect to all Elders and Cultural Custodians past and present.

We recognise Māori as tangata whenua and custodians of Aotearoa and uphold their rights under Te Tiriti o Waitangi.

About the artist

Presten Warren is a Wirangu, Dieri, Kokatha, Mirning and Arabana man based in Port Lincoln, South Australia. As a descendant of both desert and ocean tribes, his art preserves and perpetuates a 65,000-year tradition of storytelling, which was passed on to him by his mother and grandmother.

Presten has created more than 400 artworks in his career so far. He has collaborated on many major corporate, government and organisational projects, from Reconciliation Action Plans and cultural frameworks to vehicle wraps, uniforms, large-scale signage, digital animations and national campaigns.

He describes the artwork, entitled *Shared Ground* and created for *Australian Medicine in Context*, as follows:

At the centre is a meeting place, a shared ground where people come together.

Journey lines move across the piece, connecting people, places and stories across Country. They reflect movement, care and the different paths we walk.

Medicine leaves represent healing and the strength of traditional practices while mountain ranges represent the lofty heights of modern knowledge.

Greens and earth tones symbolise land and growth, while whites represent connection and our ancestors' guiding light.

This piece is a reminder that no matter where our paths lead, they always come back to shared ground.

The Australian Medical Council wishes to express sincere thanks for Presten's artistic contribution to *Australian Medicine in Context*.



Shared Ground, digital, 2026, Australia. © and image courtesy: Presten Warren; exclusive licence: Australian Medical Council.

www.prestenwarren.com/about

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Professor Lisa Jackson Pulver AM (editor-in-chief)

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Clinical Associate Professor Jill Benson AM

Jill Benson AM MB BS DCH MPH PhD FRACGP(Hon) FACRRM FARGP AFRACMA is a clinical Associate Professor and has worked as a GP for over 40 years. For the past 20 years she has mostly worked as a GP for other doctors, in remote Aboriginal communities in the Australian desert, with refugees, as a medical educator, and as a volunteer medical educator in the Pacific Islands. She has presented and published nationally and internationally about medical education, refugee health, doctors' health, Aboriginal health and mental health. She currently works for the Royal Australian College of General Practitioners focusing on the remote supervision of GP registrars, as a clinician with Doctors' Health SA, and with the AMC as a medical educationalist. She has been part of AMC MCQ writing committees for 20 years, and was previously an AMC clinical examiner.

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Peter G Devitt FRACS is a consultant surgeon. He is an examiner for the AMC and former Chairman of the MCQ Panel of Examiners. He is actively involved in creating and assessing materials to be used in the AMC examinations.

Professor Richard Doherty

Richard Doherty MBBS(Hons) FRACP DOBstRCOG is joint Deputy Chair of the Board of Directors of the Royal Children's Hospital (Melbourne). He is a paediatrician whose research and clinical background is in infectious diseases, particularly HIV and other virus infections. He has held previous appointments as Head of the Department of Paediatrics at Monash University and as Dean of the Royal Australasian College of Physicians. He has a longstanding interest in curriculum development and assessment, and was the Chair of the AMC's Board of Examiners between 2006 and 2015. He has served on several national committees and expert advisory groups on the Australian medical workforce, intern training and revalidation. He was previously a member of the Medical Board of Australia and has served on the US National Board of Medical Examiners committee developing test items for the International Foundations of Medicine® examination.

Dr Joshua Francis

Joshua R Francis PhD BAppSc(MedSc) MBBS FRACP is a consultant paediatrician and paediatric infectious diseases specialist at Royal Darwin Hospital in the Northern Territory, and a Senior Principal Research Fellow at the Menzies School of Health Research, Charles Darwin University. He leads programs in Timor-Leste and the Northern Territory focused on teaching, mentoring, health systems strengthening and research. His work on rheumatic heart disease, tuberculosis, dengue, antimicrobial resistance and other infectious disease challenges has seen him partner closely with affected communities and learn from people with lived experience who are motivated to see community-led changes in healthcare systems.

Dr Justin Gladman

Justin Gladman MD DAME SCHP is an Australian College of Rural and Remote Medicine Registrar and a Senior Lecturer at the Adelaide Rural Clinical School, University of Adelaide. Justin has extensive experience in Aboriginal health, medical education and assessment.

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Peter Harris MBBS FRACGP is a GP and Honorary Senior Lecturer in Medical Education at the University of New South Wales. Currently he is the Chair of the MCQ Assessment Panel and MCQ Results Panel of the AMC. He chairs the Population Health, Ethics and General Practice writing group. He previously coordinated the Masters in Clinical Education at the University of New South Wales and has acted as consultant for WHO, AusAID and other agencies advancing medical education in the Asia-Pacific community. He has advised Australian medical programs and postgraduate training programs on curriculum and assessment. He was an international consultant for the CanMEDS 2015 update.

Dr Frank Hume

Frank Hume MBBS FRACP MRCPsych FACBS is a retired Director of Liaison Psychiatry and former Consultant Psychiatrist at the Prince of Wales Hospital, Sydney, 1980–2022; Conjoint Lecturer in Psychiatry at the University of New South Wales, 1980–2022; Senior Clinical Examiner and Member of Clinical Appeals Panel, AMC, 1986–2022; Chairman of Psychiatry MCQ Panel, AMC, 1986–2020; and Member MCQ Examination Committee, AMC, 1986–2020.

Professor Sailesh Kumar

Sailesh Kumar MBBS MMed(O&G) FRCS FRCOG FRANZCOG DPhil CMFM is an Australian National Health and Medical Research Council Leadership Fellow, Mayne Professor and Head of the Mayne Academy of Obstetrics and Gynaecology at the University of Queensland School of Medicine, and Visiting Professor at Imperial College London. He is a Senior Specialist in Maternal–Fetal Medicine/Obstetrics at the Mater Mothers' Hospital and Royal Brisbane and Women's Hospital. His practice covers high-risk obstetrics and all aspects of fetal diagnostic and therapeutic modalities, including complex fetal interventional procedures. He trained in obstetrics and gynaecology in Singapore, the UK and Australia. He obtained his Doctor of Philosophy degree from the University of Oxford and is a Fellow of the Royal College of Surgeons of Edinburgh, Royal College of Obstetricians and Gynaecologists (UK) and Royal Australian & New Zealand College of Obstetricians & Gynaecologists. He has more than 230 publications and his area of research is prediction and prevention of adverse perinatal outcomes.

Dr Narelle Mackay

Narelle R Mackay BDS BMBS(Hons) FRANZCOG GradCertHlthProfEd is an Obstetrician Gynaecologist. Throughout her career as a specialist in women's health, and previously as a dentist, she has contributed to the education and training of undergraduate students and junior colleagues. She has been extensively involved in written, clinical and workplace-based assessment for the AMC and is a Senior Examiner in the Discipline of Women's Health. She is currently the Medicine Portfolio Assessment Convenor and Written Assessment Lead in the Office of Medical Education, Faculty of Medicine and Health at the University of New South Wales.

Professor Barry McGrath

Barry P McGrath MBBS MD (Sydney) FRACP, now retired, was Professor of Vascular Medicine at Monash University and a consultant physician at Monash Health, 1990–2015. He was inaugural Chair of the Postgraduate Medical Council of Victoria and served as Chair of the Confederation of Postgraduate Medical Education Councils of Australia.

He has been a significant contributor to the work of the AMC (1983–2022) in various roles: Senior Examiner, Deputy Chair AMC Assessment Committee, Chair Clinical Assessment Panel, Chair MCQ Medicine Panel, Member Research Committee, and Member Prevocational Standards Accreditation Committee. He had a key role in the development and standard setting for the workplace-based assessment program for

international medical graduates in Australia. He oversaw the implementation and quality improvements to the AMC examinations for international medical graduates at the National Test Centre in Melbourne. He is a member of the Publications writing group. In these various roles in medical education, he has interacted extensively with health departments, health experts, universities and academic leaders across Australia and internationally. He is author or co-author of 10 books, 11 book chapters, 226 papers in referred journals and more than 250 abstracts (h-index 54).

Emeritus Professor David Prideaux

David Prideaux DipT(Prim) BA(Hons) MEd PhD FANZAHPE is Emeritus Professor of Medical Education in the Prideaux Discipline of Clinical Education in the College of Medicine and Public Health at Flinders University. He is a former Deputy Dean and Head of Health Professional Education. He is an educator by background with special interests in curriculum, assessment and evaluation. He is currently a Technical Advisor (Assessment) for the AMC and was a Director and Chair of the Assessment Committee of the AMC from 2015 to 2023. He has published widely in the fields of clinical education and assessment and has held editorial appointments with national and international medical education journals.

Dr Maria Tomasic

Maria Tomasic MBBS (Adelaide) FRANZCP is a consultant psychiatrist who chairs the AMC Mental Health MCQ writing group and is a member of the Clinical writing group. Her past psychiatric practice includes forensic psychiatry, general adult, remote clinics in the Anangu Pitjantjatjara Yankunytjatjara Lands, other rural work, and a service for adults with developmental disabilities and mental illness. Private practice included psychotherapy and victim-impact medicolegal assessments. She was President of the Royal Australian and New Zealand College of Psychiatrists from 2010 to 2013 and held numerous other positions within the college and in the Asian Federation of Psychiatric Associations. Other past roles include membership of the Doctors Health Committee of the South Australian Medical Board, Guardianship Board, and the Management Assessment Panel. She completed a Churchill Fellowship in 2013 investigating service models for people with both developmental disability and mental illness.

Additional contributors and editors

We are grateful for contributions and advice from the people listed below.

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Professor Papaarangi Reid (Te Rarawa) FNZCPHM FRACS (Hon) is a leading Māori public health academic at the University of Auckland, where she serves as Tumuaki (Deputy Dean Māori) and Head of the Department of Māori Health within the Faculty of Medical and Health Sciences.

She is a specialist in public health medicine, holding science and medical degrees from the University of Auckland, along with postgraduate qualifications in areas including community health. Her academic and professional career has focused strongly on Māori health and equity, particularly examining disparities between Indigenous and non-Indigenous populations as a way of assessing government commitment to Indigenous rights.

Professor Reid (Te Rarawa) has an extensive research portfolio spanning decades, with work centred on health inequities, Indigenous rights, and the development of culturally safe health systems and workforces. She is widely recognised for her leadership in advancing hauora Māori (Māori health) and for building capacity within the Māori health workforce, mentoring emerging leaders in the field.

In addition to her academic leadership, she has contributed internationally through collaborations and advisory roles, including involvement in global health initiatives and commissions. Her work continues to influence policy, research and practice aimed at improving health outcomes for Māori and other Indigenous communities.

Dr Tammy Kimpton

Tammy Kimpton BMed MAVMed FRACGP is supervisor and practice owner at Scone Medical Practice. She is a Fellow of the Royal Australian College of General Practitioners. Dr Kimpton has served as a Director of the Australian Indigenous Doctors' Association and is a member of the AMC Specialist Education Accreditation Committee and the Aboriginal and/or Torres Strait Islander and Māori Committee.

Associate Professor Amanda Dawson

Amanda Caroline Dawson MBBS MS MMed FRACS is Academic General Surgeon at the University of Newcastle, Chair Surgical Clinical Scenario writing group for AMC, and Chair Clinical Examination Reference Group for AMC.

Amanda Dawson is strongly committed to the quality of the prevocational phase of the medical education continuum. A distinguished surgical scholar, she was awarded the inaugural Royal Australasian College of Surgeons and NSW Health Women in Surgery Leadership award in acknowledgement of her sustained and effective contributions to senior academic leadership roles (delivery, assessment, education research, accreditation and policy development) impacting medical education in Australia and Aotearoa New Zealand (AMC, UON, RACS).

As Clinical Dean, she leads the University of Newcastle Central Coast Clinical School with an educational pedagogy focusing on student-centred education, and is celebrated as an inspirational leader who models excellence in leadership behaviours (UON Leadership Excellence award).

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Professor Brendan Crotty AM

Brendan Crotty AM MBBS MD FRACP has worked as a gastroenterologist and general physician, and in medical education. He was the Foundation Dean of the Deakin Medical School and Executive Dean of Deakin's Faculty of Health. He has a longstanding interest in postgraduate training as Chair of the Board of the Postgraduate Medical Council of Victoria, Chair of the Confederation of Medical Education Councils and a member of the Royal Australasian College of Physicians Clinical Examinations Committee. He is a member of the AMC Prevocational Standards Accreditation Committee and chaired the recent AMC review of Australian prevocational medical education standards. He is a member of the Board of Barwon Health.

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Maree O'Keefe FRACP MBBS DCCH PhD is a general paediatrician and clinical professor at the University of Adelaide. She has worked for AMC over many years as a Senior Examiner, Clinical Examinations Chair, and Chair of the Child Health writing group. She is Deputy Chair of the Australian Health Practitioner Regulation Agency Accreditation Committee, a Principal Fellow with the Higher Education Academy (UK) and a graduate of the Australian Institute of Company Directors. She sat for many years on the South Australian Health Practitioner Tribunal and has provided advice as an independent consultant to Australian and Aotearoa New Zealand professional accreditation councils. She is a past Chair of the Royal Australasian College of Physicians Paediatric and Child Health Division Education Committee and has served as a member of the Governance Committee of the RACP Board.

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Her academic and professional journey reflects a lifelong commitment to decolonising medical education, ensuring hauora Māori is central to teaching, research and healthcare delivery. Suzanne's educational journey has been shaped by an unwavering dedication to kaupapa Māori research and health professional education.

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Deryck Charters MB ChB (Otago) FRANZCOG FRCOG DipObst (Otago) was a specialist obstetrician and gynaecologist, and the first at the Gold Coast Hospital to lead the Women, Newborn and Children's Services department, growing it into a world-class facility over his 25-year tenure. He received the prestigious President's Medal from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, a first for a Queenslander, and is remembered for his significant contributions to women's health. He has worked for AMC for many years as a Senior Examiner and a member of the Women's Health writing group.

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Acknowledgements

We would like to acknowledge the valuable contributions of several individuals who have chosen to remain anonymous. Their generosity in sharing their knowledge, perspectives and experience, along with their thoughtful and considered input, has significantly informed and strengthened this publication. We would also like to extend our sincere thanks to the Aboriginal and Torres Strait Islander and Māori contributors who provided additional review and guidance, whose insights have been instrumental in shaping the content and ensuring the work reflects cultural understanding, respect and integrity.

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Miriam Cavanagh is of Aboriginal and Torres Strait Islander heritage. Her father is a Wonnarua Aboriginal man from the Singleton area in the Hunter Valley, New South Wales, and her mother is from Aboriginal and Torres Strait Islander families, including Yirrganydji Cairns Coastal areas, Kuku Ya'u from Lockhart River in Queensland and Torres Strait Islander Zenadth Kes, from the Eastern, Central and Western Islands.

She is the Blakademy Rural First Peoples Health Lead for Aboriginal and Torres Strait Islander Health and a Senior Lecturer at the School of Medicine, University of New South Wales, Kensington, working within the Rural Health Multidisciplinary Training program and Rural Clinical Campuses.

Miriam is also an Aboriginal and Torres Strait Islander Accreditation Assessor with AMC and the Australian Physiotherapy Council, contributing to Accreditation under the National Regulation and Accreditation Scheme.

Miriam holds a Postgraduate Diploma in Indigenous Health Promotion and has undertaken extensive professional development in Aboriginal and Torres Strait Islander cultural safety in health programs accreditation, clinical governance and practice improvement in Australian hospitals, and cultural competence and capability, including trauma-informed approaches. She has also completed training in crisis intervention and management through Walamarra (CIMA), and engagement through the International Association for Public Participation Australasia across Australia and Aotearoa New Zealand, Dr Tracey Westerman Workshops in Psychological Assessment of Aboriginal Clients / The Westerman Aboriginal Symptom Checklist for Youth, LIVINGWORKS I-ASIST Australia's First Indigenous-Led Suicide Intervention Training, Indigenous Applied Suicide / Intervention Skills Training Certificate.

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Kerry Hall PhD EN is an Aboriginal Health Practitioner and learning and teaching Indigenous coordinator. With extensive experience working in Aboriginal and Torres Strait Islander health and education, her professional interests include community engagement, capacity building, health inequity and inequalities, access to health care, and social and emotional wellbeing, with a particular interest in cultural safety and culturally safe care. Kerry works collaboratively with colleagues to create, oversee, implement and assess teaching, curriculum and learning programs, ensuring alignment

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Maria Mackay PhD RN RM GradCert(PHealth) MSc(HPM) is a proud Wiradjuri woman. She is a registered nurse and midwife with extensive clinical and leadership experience. Maria is a Director of the Person-centred Practice International Collaborative of Practice CIC. Her research is focused on working collaboratively with local Aboriginal communities to improve their health outcomes. Maria completed her PhD on person-centred practice with a focus on the crafting of healthful relationships. She is also interested in research that challenges approaches to healthcare learning and teaching that focuses on the art of healthcare practice and embeds transformational approaches, including Indigenous knowledges and person-centredness.

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Esther Willing is an Associate Professor in Hauora Māori at Kōhatu Centre for Hauora Māori, Ōtākou Whakaihū Waka University of Otago in Dunedin, Aotearoa New Zealand. She is a descendant of Ngāti Toarangatira, Ngāti Koata, Ngā Ruahine and Ngai Tahu iwi. She teaches Indigenous health into medicine, dentistry, oral health and health sciences, and her research focuses on the ways in which health policy and health services can improve Māori health outcomes and address health inequities.

We also acknowledge the many people who have provided advice and feedback on this book in a variety of formal and informal ways.

Introduction

Australian medicine in context aims to help three broad groups.

It is primarily designed to be a guide for international medical graduates (IMGs) who wish to practise in Australia, but first are required to pass the Australian Medical Council (AMC) assessments. As such, it is essentially a guide to what is examinable.

The second readership is those who write questions for the AMC examinations or those wishing to devise assessments in medicine and other health-related disciplines. It is preferable that all AMC assessment questions are drawn from the topics in this book.

The third is Australian medicine students. As this book aims to set out what is needed at the point of graduation as a doctor, medical students nearing the end of their course will find this book useful for revision.

This book is not intended to be a textbook or to give all the answers asked by those studying for examinations. Instead, it aims to be used more as an aide-mémoire or guide to recognise any gaps in their knowledge.

This book replaces the *Anthology of medical conditions* published by the AMC in 2003. This revision improves on the first edition in several ways:

1. It focuses on patient presentations (see pages 50–237). It has less emphasis on conditions, as the details of these are liable to change over time.
2. The generic skills needed by doctors that are not specific to any particular patient presentations—previously referred to as ‘legal, ethical and organisational (LEO)’ topics—are referred to here as ‘professional practice’ topics (see pages 238–330). This edition includes these in a similar format to the patient presentations, thereby making them more explicitly examinable.
3. Material on cultural competence in medical care in the Australian context has been strengthened within the professional practice topics.

Where applicable, each patient presentation provides some Australian context to indicate more common presentations in Australia, or those that are less common but important not to miss. Also highlighted in each relevant patient presentation and professional practice topic are common challenges faced by doctors and diagnoses that might otherwise be overlooked. The summary views of experts encapsulate some of these challenges.

An index of conditions mentioned in this book is provided (see pages 331–346), particularly those that have been suggested in consideration of a work-up for a patient. This conditions index is useful to the reader as a checklist of diseases with which to be familiar. There has been no attempt to assign any priority to the conditions, or to explain the depth of knowledge required. Essentially, the knowledge of conditions needs to be sufficient to manage the presentations seen by a newly graduated doctor. Some conditions will need in-depth knowledge of management; others simply need

to be considered as part of a differential diagnosis, where further investigation and treatment might be better undertaken by those with more specialised knowledge. As a guide, serious life-threatening or treatable conditions should always be considered. The more prevalent conditions will require more in-depth knowledge of investigation and treatment.

By using this book, the reader may gain insight into areas of competence and confidence, as well as areas where more learning is required.

Preparing for Australian Medical Council examinations

The AMC provides resources for IMGs [1] that comprise reference material and background reading on key topics. They are not intended as prescribed reading.

The AMC examination process assesses, for registration purposes, the medical knowledge and clinical skills of IMGs whose basic medical qualifications are not recognised by the Medical Board of Australia.

The process is designed as a comprehensive test of medical knowledge and clinical competence. There are two stages, the multiple-choice question (MCQ) examination and the clinical examination. Both the MCQ and clinical examination are multidisciplinary and integrated.

The MCQ examination focuses on basic and applied medical knowledge across a wide range of topics and disciplines, involving understanding of disease process, clinical examination, diagnosis, investigation, therapy and management, as well as on the candidate's ability to exercise discrimination, judgement and reasoning in distinguishing between the correct answer and plausible alternatives. The MCQ is a computer-administered examination.

The clinical examination assesses the candidate's capacity in such areas as history taking, physical examination, diagnosis, ordering and interpreting investigations, clinical management, and communication with patients, their families and other healthcare workers.

Australian Medical Council examination specifications

The AMC provides guidelines and specifications to help candidates with the AMC MCQ and clinical examination [2].

The guidelines contain information about:

- the format and content of the examination
- the levels of clinical knowledge, skills and attitudes necessary to satisfy the requirements of the examination
- the areas and topics covered in the examination
- preparing for the examination
- suggested reading lists for the examination.

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Practising medicine in Australia

There are several transitions when starting to practise as a doctor in Australia. For a student, the biggest transition when becoming a doctor is in understanding all the responsibilities it entails.

For those who already practise medicine, but qualified as doctors outside of Australia, many aspects of their practice will be the same. The nature of many illnesses, how they present and the treatments available are similar globally. However, there will be differences—the prevalence of many illnesses is different in Australia compared with other countries and even varies depending on location within Australia.

The impact of colonisation and its subsequent effect on health has severely disadvantaged Aboriginal and Torres Strait Islander people since the beginning of colonisation. Government and non-government programs that target specific healthcare requirements of Aboriginal and/or Torres Strait Islander people, many of which are a result of the annual Closing the Gap work [1], have had some success, although not as much as anticipated. Some programs include strong cultural practices such as gendered healthcare clinics, and birthing programs at home and on country [2]. The Closing the Gap program was an outcome of the Australian Government's formal Apology to Aboriginal and Torres Strait Islander people on behalf of the Australian people for the practices of forcibly removing children from their families [3]. These are but two of the many attempts of government and other independent agencies to try and make good many of the wrongs committed in the past. In the medical context, this includes MSI Australia's apology for the forced medical procedures conducted on Aboriginal and Torres Strait Islander people on the basis of racist colonial ideas [4].

Other groups, such as migrants and refugees, and those living with disabilities, will also have different and identifiable health needs. Social, economic, geographical, health and many other factors, as well as the ways they often overlap (i.e. their intersectionality), will influence the differential diagnoses being considered when assessing patients in the context of their families and their communities, and are important when considering disease prevention, intervention and health promotion strategies. The organisation of health services differs from many other countries and, within Australia, can differ between states and territories.

The organisation of care, and access to it, may vary by location (e.g. urban, regional and remote areas of Australia) or by funding (e.g. private or public provision, or an Aboriginal community-controlled health organisation). Distance also becomes an important factor in medical decision making in both outer regional and remote communities. Access, even in the big cities, can be problematic and needs to be considered when planning patients' ongoing care.

Equally important is the culture within a medical practice or health service. This culture influences how people interact within a healthcare team, how error is regarded and managed, how health professionals work together, and how patients and their communities are engaged in management decisions or when there is diagnostic uncertainty.

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Who are Australians?

Today there are over 27 million people who call Australia home, representing just 0.33% of the world's population. Approximately two-thirds of Australia's population live in a capital city, and immigrants accounted for 32% of the population in 2025 [1]. The median age of the Australian population is around 38 years [2].

People seeking to become residents of Australia are asked to sign a Values Statement [3], which includes the following:

- respect for the freedom and dignity of the individual
- freedom of religion (including the freedom not to follow a particular religion), freedom of speech, and freedom of association
- commitment to the rule of law, which means that all people are subject to the law and should obey it
- parliamentary democracy whereby our laws are determined by parliaments elected by the people, those laws being paramount and overriding any other inconsistent religious or secular 'laws'
- equality of opportunity for all people, regardless of their gender, sexual orientation, age, disability, race, or national or ethnic origin
- a 'fair go' for all that embraces mutual respect, tolerance, compassion for those in need, and equality of opportunity for all
- the English language as the national language, and as an important unifying element of Australian society.

Australia's multicultural society

Migrants have long made up a large component of the Australian population, as shown by their inclusion in the first national Census in 1911 [4]. Until around 1868, Britain transported more than 160,000 convicts and 200,000 'free settlers' to Australia. Other early migrant groups were Chinese and Afghan people. Many South Sea Islander people were stolen from their own lands and forced into labour on sugar plantations. Japanese people became a growing part of the pearling industry. Australia has not yet acknowledged its role in slavery, both on the forced servitude of Aboriginal and Torres Strait Islander people and on the taking of people from many South Sea Islands. Enacted in 1901, the *Immigration Restriction Act* (Cth) (aka the White Australia policy) restricted migration to Australia, and wasn't repealed until the 1970s. Today there are increasingly more Australians who were born in Asia and other parts of the world [1].

The contribution of migrants from all parts of the world to Australian society, culture and prosperity is reflected in the diversity of languages, religions, ancestries and birthplaces reported by Australians in the Australian Census [5].

First-generation Australians are people living in Australia who were born overseas. This is a diverse group of people including Australian citizens, permanent residents and long-term temporary residents. In 2025, 8.8 million people living in Australia were born overseas [1].

In the 2021 Census, 22% of the Australian population had at least one parent born overseas, thus making them second-generation Australians [5].

Australians who are third generation and over are people who were born in Australia, and whose parents were both born in Australia. One or more of their grandparents may have been born overseas or they may have several generations of ancestors born in Australia.

Over 22% of people speak a language other than English at home, but for almost three-quarters of Australians, English is their only language.

Australia offers a free interpreting service over the phone (in over 150 languages, including Auslan) for doctors to use with patients at any time [6]. There is a skill set required to work with accredited interpreters: doctors need to be proficient and confident to ensure that the interaction is confidential and clear, and that the information has been correctly relayed.

Australia's diverse society

Service accessibility is also important for people who are living with disabilities. One example is those who are deaf and hard of hearing. While some wear hearing aids or can lip-read, many require captions or are users of Auslan, the language of the Australian Deaf community [7,8]. The 2021 Australian Census asked respondents if they used Auslan in their homes and found more than 16,000 users, a figure that had significantly increased since the previous Census [9]. However, around 20,000 people are known to use Auslan in their everyday lives. This number is expected to increase, as there are around 3.6 million people who have hearing loss in Australia; between 2014 and 2015, over 364,000 hearing devices were prescribed [10]. Notably, Aboriginal and/or Torres Strait Islander people experience significantly higher rates of preventable hearing disorders than non-Indigenous Australians. Otitis media is also common and, if left undiagnosed or poorly treated, can result in hearing loss or deafness. Cataracts and blindness are also common among Aboriginal and/or Torres Strait Islander populations, with those in some communities suffering endemic trachoma.

At least 1.8 million people live with a disability and require formal assistance for at least one activity of everyday living. In 2022, 39.4% of people aged under 65 years living with a disability reported this as an unmet need [11]. The needs of all disadvantaged groups must be addressed so Australia can progress as a fair, equitable and just society.

Although many Australians are prosperous, ranked among the highest income-earning citizens in the world, Australia is not without suffering. There are globally high rates of suicide [12], psychological distress, depression and anxiety [13], and non-communicable diseases [14]. There is significant and worsening income inequality.

The presentations of illness and expectations of the health profession differ according to culture, especially regarding mental health issues, disabilities and chronic diseases. Such differences in presentation may be particularly pronounced in first-generation Australians, refugees and new immigrants. There may be cultural implications with everyday life such as meals and clothing, and particularly at times of life transition such

as birth, parenthood, ageing and dying. Relationships with family, community, spiritual Elders, other genders and people in authority (such as doctors) will be influenced by country of origin, values, beliefs and religion. These cultural implications can impact on healthcare and ethical considerations. For some cultures, it is not the individual who makes health-related decisions: these may only be made in consultation with extended family, Elders or spiritual advisers.

Culture is not only embodied in ethnicity, but also in gender, sexuality, religion, education, age, disability, occupation, socioeconomic status, language, and each individual's past and present circumstances. Adequate communication begins with the medical practitioner reflecting on their own culture and with cultural curiosity about the other person's (patient or colleague) approach to the problem and expectations. It requires not only flexibility, cultural humility and respect, but also the understanding that no-one can fully understand another person's culture. So, the practitioner must be culturally aware and culturally sensitive so that patients are culturally safe in order to access optimum health care.

See also

- [Cultural safety terminology and definitions >](#)
- [Cultural implications of life transitions >](#)
- [Implicit bias and racism >](#)
- [Interpreters >](#)

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Aboriginal and/or Torres Strait Islander peoples

Australia is home to peoples who belong to the oldest existing continuing culture on the planet.

Aboriginal and Torres Strait Islander peoples have a strong relationship with the lands, waters and skies of this place, which today is known as Australia. This relationship dates back at least 65,000 years [1], and as such, these peoples are considered to have the oldest continuing culture on Earth [2–4]. Their oral traditions record much history. Some of these histories include stories of relationships and trade that span all parts of Australia and its neighbours over millennia, as well as the ‘preserved memories of Australia’s coastline dating back more than 7000 years’ [5]. Aboriginal and/or Torres Strait Islander peoples have sophisticated legal, health, science, kinship, food harvesting and landcare systems [6,7]. The intergenerational knowledge sharing, cultural practices and relationship with the lands, waterways and skies across many thousands of years informs Aboriginal and/or Torres Strait Islander peoples’ ideas about health and wellbeing [8]. Relationships with community, society and the environment are inextricably connected to health and wellbeing. This has important implications for doctors practising in Australia.

In 2021, an estimated 812,728 Australians disclosed they are of Aboriginal and/or Torres Strait Islander origin [9]. Most (91.4%) were of Aboriginal origin, 4.2% were of Torres Strait Islander origin, and 4.4% disclosed being both [9]. The Northern Territory has the highest proportion of Aboriginal and/or Torres Strait Islander peoples (30.8%). New South Wales and Queensland are home to the greatest number of Aboriginal and/or Torres Strait Islander people. The median age of Aboriginal and/or Torres Strait Islander people was 24 years in 2021. This is younger than the median age of 38 for non-Indigenous Australians [10].

Before 1788, there were over 250 languages, and 500 dialects were spoken, with people living in accordance with the seasons, food supply from the waters and the land, and shelter. Some were known to create fish and eel traps, some of which are still in place today. Others were known to be agriculturalists, with knowledge of Aboriginal farming practices and the use of native grains coming to the fore now. Aboriginal and Torres Strait Islander people had complex social structures and were connected to the land through their cultural and spiritual beliefs.

The arrival of European settlers marked the beginning of a devastating era for Aboriginal and Torres Strait Islander peoples, characterised by land dispossession, violence and disease. This period also saw the implementation of policies that led to the Stolen Generations, which refers to the children of Aboriginal and/or Torres Strait Islander descent who were forcibly and systematically removed from their families by government agencies, church missions and others. This is just one stark example of systemic racial injustice and profound force that continue to affect many Aboriginal and Torres Strait Islander communities today.

The removal of children was based on the belief that they would eventually assimilate into white society, erasing their cultures and identities, language and names, stories

and belonging in the process. The intent was to eradicate rights, to dominate absolutely the lives of these children, setting up profound and enduring consequences that contribute to intergenerational trauma, loss of cultural identity, familial disconnections, community dislocation and socioeconomic disadvantages. These issues persist to this day.

Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines

Aboriginal and/or Torres Strait Islander health workers and Aboriginal and/or Torres Strait Islander health practitioners are two distinct but related professions that together comprise the Aboriginal and/or Torres Strait Islander health workforce.

As the only Indigenous ethnic-based health workforce in Australia with national training and regulation, Aboriginal and/or Torres Strait Islander health workers and health practitioners are unique among other health professional groups. The professions, established by Aboriginal and Torres Strait Islander people *for* Aboriginal and Torres Strait Islander people, play a vital and critical role in ensuring Australia's healthcare system meets the needs of Aboriginal and Torres Strait Islander people. With lived experience in and a deep understanding of the communities they serve, Aboriginal and/or Torres Strait Islander health workers and health practitioners provide a high standard of culturally safe and responsive care, act as cultural brokers and health system navigators, and are crucial to easing the anxiety resulting from negative experiences with health research and care in the past [11]. Their combination of clinical, cultural, social and linguistic skills delivers engagement capability and community reach that sets them apart from professions working in the healthcare system. Evidence directly connects this workforce to improved Aboriginal and Torres Strait Islander health outcomes across the life course [12].

Aboriginal and/or Torres Strait Islander health workers and health practitioners receive practical, comprehensive primary healthcare training through the vocational education and training (VET) system, with their qualifications ranging from a Certificate II to an Advanced Diploma. Of the two professions, Aboriginal and/or Torres Strait Islander health practitioners are trained to perform a higher level of clinical skills while working in an autonomous manner. They are required to meet practice standards and register with the Aboriginal and Torres Strait Islander Health Practice Board of Australia within the Australian Health Practitioner Regulation Agency (Ahpra) [13].

Aboriginal and/or Torres Strait Islander health workers and health practitioners work autonomously and in multidisciplinary teams across primary, secondary and tertiary healthcare settings. They are employed in Aboriginal and/or Torres Strait Islander community-controlled health services, government hospitals and health services, and private practice. If enabled to do so, they can provide a range of generalist and specialist healthcare services. Depending upon qualification, work setting and individual scope of practice, this includes:

- assessment and screening of physical health and social and emotional wellbeing, particularly through participation in the provision of 715 health checks [14]
- providing care in line with General Practice Management Plans, Team Care Arrangements, training and/or treatment protocols
- assisting with GP Mental Health Treatment Plans, treatment consultations and reviews, and Home Medicines Reviews (aka Domiciliary Medication Management Reviews)
- providing health promotion and health education advice and programs
- supporting clients in self-management, including the safe use of traditional and Western medications
- advocating for clients' and communities' healthcare needs
- planning, delivering and evaluating population health programs
- advocating for clients, including interpreting and translating language
- providing advice, support and training on providing culturally safe healthcare services to colleagues
- supporting diagnosis and treatment using advanced clinical skills such as electrocardiograms, phlebotomy collection, and administration of medications consistent with state/territory and clinical guidelines
- supporting Chronic Disease Management plans, child and maternal health services, social and emotional wellbeing programs, palliative care services, renal dialysis and more.

Aboriginal and/or Torres Strait Islander health workers with a Certificate III or higher and Aboriginal and/or Torres Strait Islander health practitioners are eligible to apply for Medicare provider numbers. Those determined as eligible can perform and claim specific Medicare Benefits Schedule (MBS) items, both in their own right, and on behalf of a general practitioner (GP).

For more information about the professions or on how to effectively use them in culturally safe and effective models of care, please contact the National Association of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners (NAATSIHWP).

The use of Indigenous medicines

Indigenous Australian medicine involves the use of plant- and animal-based remedies, spiritual healing and physical therapies that have been passed down through generations. Some key aspects are listed below.

- Traditional Indigenous healing is holistic, addressing the physical, emotional and spiritual health of individuals. This contrasts with the often more symptom-focused approach of Western medicine.
- The knowledge of medicinal plants and their uses is extensive, varying significantly across different regions and communities. Such knowledge includes the identification of specific plants that can be used for healing, the parts of the plant to be used, and the appropriate preparation methods.

- In some communities, there is a move towards integrating traditional medicines with conventional medical treatments. Research and formalisation of traditional knowledge are part of this process, helping to validate and preserve Indigenous practices while ensuring they meet safety and efficacy standards.
- The use of traditional Indigenous medicines faces challenges, including issues of intellectual property rights, resource sustainability, and legal restrictions on the use of certain plants and animals.

Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines are vital components of health care for Indigenous communities in Australia. Their work not only improves health outcomes but also helps in the preservation and recognition of Indigenous culture and practices.

Historical and political determinants of health

Colonisation disrupted cultural and knowledge practices for many Aboriginal and Torres Strait Islander peoples; work continues today across affected communities to renew, develop and practise culture and knowledge.

Since commencement of the European colonial process, Aboriginal and Torres Strait Islander peoples have been subject to a range of government policies that have adversely affected their good health and wellbeing. Early Western European colonisers judged Aboriginal and Torres Strait Islander peoples as uncivilised and sought their elimination [15,16]. This resulted in hundreds of massacres which, alongside introduced diseases, reduced the estimated Aboriginal population of well over 750,000–800,000 in 1788 to 117,000 by 1933 [17–19]. This was followed by protectionist and segregationist policies (1890 to 1950s) which sought to separate Aboriginal people from their families and communities [19].

At the beginning of the Federation of Australia in 1901, Australia's first Prime Minister argued that the equality of humankind did not include racial equality of those not considered 'white':

There is no racial equality. There is that basic inequality. These races are, in comparison with white races ... unequal and inferior [20].

There was also the belief among European colonisers that Aboriginal and Torres Strait Islander peoples were dying out [21]. This ensured that empathetic approaches to governance were not extended to Aboriginal or Torres Strait Islander peoples.

The assimilationist policy era (1940s to 1960s) reinforced misconceptions about Aboriginal and Torres Strait Islander cultures and beliefs that they should act and live in accordance with white European culture. High rates of government-enforced child removal produced multiple Stolen Generations [19,22]. The integration policy period (1967–1972) paid little attention to the poor health and social conditions produced by decades of oppression. The 1967 Referendum ensured that the Australian Government could make laws for Aboriginal and Torres Strait Islander peoples, and they could all be included in population counts [17]. A shift to self-determination

(1972–1975) recognised the right for Aboriginal and Torres Strait Islander people to be involved in decision making about their lives, but this approach was short-lived. Self-management (1975–1990) focused on local management of government projects, but with Aboriginal and Torres Strait Islander people having little say in the decisions. This approach was followed by a formal decade of national reconciliation (1991–2000) [23].

The consequences of this policy history on health for Aboriginal and Torres Strait Islander people are significant. Intergenerational trauma was created through the forcible separation of children from their families during the Stolen Generations. This trauma is reinforced today. In 2024, Aboriginal and/or Torres Strait Islander children were 9.6 times more likely to be removed from their families than non-Indigenous children [24]. As late as the 1970s, Aboriginal and Torres Strait Islander women were targeted for birth control and forced sterilisation procedures [25]. In 2022, MSI International issued an apology to Aboriginal and Torres Strait Islander people for their role in ‘forced sexual and reproductive procedures’ [26].

The current policy period is an extension of the reconciliation era. This has included efforts to mainstream Aboriginal and Torres Strait Islander service provision [27]. Biases such as mainstreaming are similar to recent history where significant decisions about Aboriginal and Torres Strait Islander people were made in the absence of Aboriginal and Torres Strait Islander people.

Since 2008, the federal government has engaged in a strategy known as Closing the Gap. This commitment to achieve equal outcomes for Aboriginal and Torres Strait Islander peoples has produced mixed results [28]. Since the 1970s, the government has vacillated in its commitment to Aboriginal and Torres Strait Islander self-determination. Australia only affirmed support for the *United Nations Declaration of Rights of Indigenous Peoples* (UNDRIP) in 2008, after initially voting against it in 2007 [29]. Self-determination is noted as a special and collective right of Aboriginal and Torres Strait Islander peoples under UNDRIP [30].

There are profound consequences of the policy history of Australia when it comes to Aboriginal and Torres Strait Islander peoples. This includes intergenerational impacts on health and wellbeing, and the profound and often recognised benefit this has had to generations of non-Indigenous Australians, the Commonwealth and modern-day Australia as a whole [31].

There continue to be examples in more recent years, in which Australians have been asked whether or not to include recognition of Aboriginal and Torres Strait Islander people in the Constitution.

In the 2023 Voice to Parliament referendum, Australians were asked two questions about Aboriginal and Torres Strait Islander people. One was about including recognition of Aboriginal and Torres Strait Islander people in the Australian Constitution. The second was around how Aboriginal and Torres Strait Islander people should have a voice in matters that concern them. These propositions were not agreed to in the 2023 referendum, and many are now seeing this failure as being inconsistent with Australia’s confirmed support for UNDRIP and other instruments of human rights [32].

Social determinants of health

Understanding the social determinants of health and ensuring cultural safety are crucial aspects of medical practice in Australia. These concepts are integral not only to improving individual patient care but also to enhancing the health of communities and addressing broader public health challenges. Some key aspects include the following:

- Social determinants of health—including socioeconomic status, education, physical environment, employment and social support networks, alongside race, gender and age—affect a wide range of health, functional and quality-of-life outcomes and risks. By understanding these factors, healthcare providers can better address the root causes of health issues, not just the symptoms.
- Knowledge of social determinants enables medical practitioners to tailor their interventions more effectively. This can mean advocating for community-level changes or adapting health services to meet the specific needs of certain populations, thereby reducing health disparities.
- By addressing social determinants, healthcare professionals can implement more effective preventive measures, reducing the burden of diseases and associated healthcare costs.
- Understanding and respecting the cultural backgrounds of patients, particularly Aboriginal and/or Torres Strait Islander people, is essential for providing effective health care. Culturally safe practices help build trust between patients and practitioners, improve patient engagement, and lead to better health outcomes.

To understand Aboriginal and/or Torres Strait Islander ill health, one must first acknowledge the impact of dispossession, theft, genocide, lost and Stolen Generations of families, and the decimation of the innumerable cultures of the people inhabiting Australia before 1770. Furthermore, Aboriginal and/or Torres Strait Islander health is not just the domain of the healthcare system. Given the disproportionate weight of physical and socioeconomic factors and the inequity of these with other Australians, it needs a multifaceted approach covering all aspects of people's lives, including housing, education, employment and social justice. Physical and symptomatic relief of disease will not in itself redress the burden of Aboriginal and/or Torres Strait Islander ill health [33].

Closing the Gap was initiated after the publication of the *Social justice report 2005* [34]. Initially, the report called for achieving equity for Aboriginal and Torres Strait Islander peoples in life expectancy within 25 years. Since then, non-government agencies and others came on board, and today several priority reform indicators drive the work of the Joint Council on Closing the Gap [35]. Despite this, Aboriginal and Torres Strait Islander people do not enjoy the benefits given to others in this developed country, with 26% stating their health to be 'fair' or 'poor' in 2018 [36].

Aboriginal and Torres Strait Islander people have some of the worst outcomes in health in Australia. It is critically important that people in community contexts as well as those in rural and urban contexts are afforded good-quality health care. Doctors will strengthen the care they offer by learning the local norms, language and customs.

It is important to foster relationships with Aboriginal and Torres Strait Islander health workers, teachers and other professionals to establish relationships built on trust throughout the community. Doctors are responsible for learning about the community or communities that they serve. Strengthening their cultural competence is vital to providing appropriate health care and health advice.

In Australia, the understanding of social determinants and cultural safety in medicine is not just about enhancing patient and community health outcomes—it also aligns with legal and professional standards set forth by Ahpra and the Medical Board of Australia. These standards help ensure medical practitioners have the tools and knowledge to address health inequities effectively and ethically. As such, medical professionals are encouraged to integrate this understanding into their daily practice, thereby fulfilling both their ethical obligations and regulatory requirements.

Social and emotional wellbeing is central to understanding health care for Aboriginal and Torres Strait Islander populations in Australia [37]. Health is not just the physical wellbeing of an individual but a holistic concept that includes the whole community's cultural, spiritual and emotional wellbeing [38]. The key elements and importance of addressing social and emotional aspects in health care for these communities are discussed in depth below.

Holistic view of health

For Aboriginal and Torres Strait Islander people, health encompasses much more than the absence of disease. It involves the social, emotional and cultural wellbeing of the entire community, with each aspect interconnected and equally important. This holistic view is deeply rooted in a connection to the land, culture, spirituality, ancestry, family and community.

Importance of social and emotional wellbeing

- Strong connections to community and culture are protective factors that enhance individuals' mental health and wellbeing. Healthcare services that respect and promote these connections tend to be more effective and better received.
- The legacy of colonisation, including dispossession, cultural dislocation and the Stolen Generations, has profound ongoing impacts on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Healthcare providers need to understand and consider these historical contexts when planning and delivering care.
- Culturally safe practices are essential for effective healthcare delivery. This means creating an environment that is spiritually, socially and emotionally safe, as well as physically safe, where there is no assault on a person's identity or wellbeing. It also involves recognising the impact of one's own culture on healthcare delivery.
- Mental health issues, while common in all communities, have specific nuances in Aboriginal and Torres Strait Islander communities. Issues such as grief, loss, trauma and the effects of past policies of forced removal are prevalent and must be approached with sensitivity and awareness of cultural context.

- The roles and structures of family and kinship are significantly different in many Aboriginal and Torres Strait Islander communities compared to non-Indigenous settings. Healthcare plans and interventions need to consider these structures to ensure they are appropriate and effective.

Addressing the social and emotional aspects of health care is critical to improving health outcomes for Aboriginal and Torres Strait Islander people. By embracing a holistic approach that incorporates these elements, healthcare providers can offer more effective, respectful and culturally appropriate care. This approach not only supports individual health improvements but also fosters the resilience and wellbeing of entire communities.

Aboriginal and Torres Strait Islander views of health

The Aboriginal definition of health has social and emotional wellbeing and their determinants intertwined within, and clearly states that:

‘Aboriginal health’ means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life [39].

This definition, which can be compared to wording in the 1989 Aboriginal health strategy [38], and like the 1978 Declaration of Alma-Ata [40], recognises the need to address the context in which people live. The Aboriginal community-controlled health service model of culturally appropriate comprehensive primary health care, which emerged in the early 1970s, notes that the health of the individual is tied to that of the community, society and environment and vice versa [40–42].

Ill health is more than physical illness; it is a manifestation of other factors, and can include spiritual and emotional alienation from land, family and culture. Aboriginal and Torres Strait Islander people have a spiritual link with the land that provides a sense of identity, and which lies at the centre of their spiritual beliefs [33]. This means that Aboriginal and Torres Strait Islander people’s connection with their lands, skies and waterways, and to their community, are intrinsically part of wellbeing and health. This places into context the challenges to health, social and emotional wellbeing that are concomitant with the history of disenfranchisement, violence, sense of loss, familial separation, and marginalisation that Aboriginal and Torres Strait Islander people face in contemporary Australia. Understanding the history of Australia, the effects of colonisation, how issues such as gender-related differences and imposed religious norms and views have had an impact on people over the decades and generations, all contribute to your capacity to offer respectful and appropriate health care.

Aboriginal and Torres Strait Islander people’s understanding of gender can influence health care. Part of this understanding may be termed ‘women’s business’ and ‘men’s business’. The specifics of what counts as men’s business or women’s business depends on the community.

Practising doctors need to be aware that consultations may require specific skills or may need to be referred on appropriately to optimise health outcomes.

There are a variety of supports in place for Aboriginal and/or Torres Strait Islander parents-to-be and infants. Make sure that you are up to date on the supports offered by your local area health network and the Aboriginal community-controlled health services in your region. Research the relevant Aboriginal and/or Torres Strait Islander health services offered in the state or territory where you work and connect with local Aboriginal and/or Torres Strait Islander health practitioners across your community so you are well-equipped to refer parents-to-be and infants on to culturally responsive health services [43]. Hearing health, eye health and oral health are important considerations when seeing Aboriginal and/or Torres Strait Islander children [44].

What Aboriginal and Torres Strait Islander peoples have endured since colonisation is shocking and it affects how they engage with Australia's healthcare system. Many people avoid care. Many wait until they are so sick that only the most drastic of measures can possibly help them. It doesn't matter if someone is living next door to a hospital, or a clinic, or in remote Australia—there are still barriers to access.

Part of a doctor's job is to help people understand that their health is as important as the health of any other Australian.

See also

- Cultural safety terminology and definitions >
- Cultural implications of life transitions >
- Establishing Indigenous Australian status >
- Extended family and community relationships >
- Genetic testing and DNA sovereignty >
- Historical and intergenerational trauma >
- Implicit bias and racism >
- Patient-centred care >

Useful resources

- Australian Indigenous Doctors' Association. <https://aida.org.au> (accessed May 2026).
- Lowitja Institute. <https://www.lowitja.org.au/> (accessed May 2026).
- Menzies School of Health Research. Ask the specialist: a cultural education podcast. https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/Ask_the_Specialist_a_cultural_education_podcast/ (accessed May 2026).
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Culture of medicine in Australia

Medicine has a culture of its own that differs across the globe. In many countries, a doctor has a position of authority over patients and other health professionals, and there is a clear hierarchy within the profession. In Australia, there is much less hierarchy, with an expectation for patient-centred and team-based care, and it is a common and widely accepted practice to ask for or seek a second opinion. Doctors are expected to have a commitment to constant self-improvement, including self-directed learning, audits, peer support and the use of evidence-based practice.

Doctors should practise the 'art' of medicine as well as the 'science', using good communication skills, compassion, cultural awareness, respect, altruism, self-

reflection, honesty and professional boundaries. There are ethical and legal obligations and standards that must be applied to all consultations, such as informed consent, confidentiality and record keeping.

Patient-centred care and shared decision making should be the foundation of all interactions. This involves doctors, patients, families and, in some instances, communities engaging in a mutual identification of the problem list, negotiating an evidence-based management plan, and agreeing about roles, responsibilities and timelines. The doctor–patient relationship is a partnership, and the patient—and their family, if appropriate—should understand the nature of the illness, its likely progress, the advantages and disadvantages of the management plan, and the timeframe for review.

Team-based collaborative care may involve other doctors, allied health professionals, nurses, midwives, Aboriginal and/or Torres Strait Islander health workers, psychologists and others. It is essential for doctors to recognise their own limitations and to seek appropriate assistance from other professionals, with adequate handover, clear interprofessional communication and open disclosure within the team. Referral from a generalist to a disease- or discipline-specific specialist and vice versa, requests for advice, and sharing information with colleagues should all be part of everyday practice. However, good medical practice also involves dealing with uncertainty, appropriate triaging of patients according to their risk of unfavourable outcomes, and the development of a flexible plan to deal with changing situations. If there is any doubt, it is always appropriate for a patient to consider a second opinion, and for a doctor to facilitate this.

See also

- [Charter of healthcare rights >](#)
- [Continuing professional development >](#)
- [Duty of care >](#)
- [Equitable access to care >](#)
- [Improving patient safety by speaking up >](#)
- [Interprofessional collaboration >](#)
- [Open disclosure, dealing with errors, adverse events and complaints >](#)
- [Recognising limitations and calling for help >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)
- [Resource allocation >](#)

Status of health in Australia

Doctors working in Australia should have a thorough understanding of the context in which they work, including an appreciation for the burden of disease affecting the general population, considerations for specific groups, and the impact of social determinants of health.

Information on the status of health in Australia is regularly updated. The Australian Institute of Health and Welfare produces publications about the status of health in Australia [1] and the burden of disease in Australia [2]. The [Appendix](#) lists common causes of death and common problems seen in general practice and emergency departments.

National Health Priority Areas

The National Health Priority Areas have been established by the federal, state and territory governments [3]. They are intended to focus public attention and health policy on areas that are considered to contribute significantly to the burden of disease in Australia, and for which there is potential for health gain. Doctors in Australia should be familiar with public health and clinical aspects of these nine National Health Priority Areas:

- arthritis and musculoskeletal conditions
- asthma
- cancer control
- cardiovascular health
- dementia
- diabetes mellitus
- injury prevention and control
- mental health
- obesity.

Social determinants of health in the Australian context

Social determinants of health are factors that influence health outcomes for individuals and groups, positively or negatively [4,5]. Key social determinants of health in Australia include but are not limited to those listed below.

- **Socioeconomic group** is related to educational attainment, occupation and income. People in lower socioeconomic groups have lower life expectancy.
- **Early life experiences**, including perinatal history, early childhood development and nutrition, have been shown to have long-term impacts on health.
- **Social exclusion**, such as through unemployment, discrimination, stigmatisation and poverty, can adversely affect health.
- **Social capital** describes the benefits obtained from the links that bind and connect people within and between groups.

- **Employment and work** are important contributors to health, and unemployed people have higher risk of death, illness and disability than those of similar age who are employed [6].
- **Residential environments** that ensure affordable and secure housing with appropriate supporting infrastructure, such as transport and recreational space, are associated with better health.
- **Historic factors** include forced removal of children from family and community, denial of the right to use one's own language, exclusion from education, and other racist practices that still have an effect today [7].

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Health promotion and illness prevention

Health promotion is an active health initiative in which Australian health practitioners have important roles to play for the communities, groups and individuals among which and for whom they work [1–3].

The World Health Organization defines health promotion as:

The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions [4].

The World Health Organization also identifies that Indigenous peoples’ concept of health and wellbeing is holistic and encompasses spiritual, environmental, cultural and social dimensions in addition to physical and mental health. They view health as both an individual and a collective right, strongly determined by community, land and the natural environment. Indigenous peoples’ approach to health is a balance of spirituality, traditional medicine, biodiversity and the interconnectedness of all that exists. This leads to an understanding of humanity in a significantly different manner from that of mainstream society [5]. It’s a dynamic concept that can work for all people, often beyond the defined primary, secondary and tertiary prevention processes of mainstream medicine, which can often be limited in their consideration of the needs of Indigenous peoples and non-mainstream practices.

Primary prevention focuses on preventing someone from contracting an illness; this can be through raising awareness (e.g. sun protection), regulation (e.g. smoking restrictions), community values (e.g. dental hygiene) or public health measures (e.g. immunisation). Secondary prevention focuses on trying to detect a disease early and prevent it from getting worse. Tertiary prevention aims to reduce morbidity and mortality for individuals who have a disease. Examples of each of these are shown in Table 1.

Table 1. Examples of prevalent diseases in Australia and health promotion and prevention measures

Condition	Primary	Secondary	Tertiary
Carcinoma of the cervix	Human papillomavirus vaccination; barrier protection	Cervical screening programs	Colposcopy procedures
Colorectal cancer	Diet; smoking cessation	Population faecal occult blood testing (FOBT)	Surveillance after low-grade polyp dysplasia or positive FOBT

(Cont.)

Condition	Primary	Secondary	Tertiary
Diabetes mellitus	Diet; exercise	Diagnosis and medication for glucose control and kidney protection	Risk-factor control and surveillance of end-organ disease (e.g. cardiovascular system, eyes or kidneys)
Skin cancer	Use of sunscreen, especially among children	Regular skin checks for at-risk groups	Removal of skin cancers
Chronic obstructive lung disease	Smoking cessation programs; public restrictions to smoking	Review of at-risk groups; early treatment of infection	Use of medication to improve lifestyle

See also

- [Advocacy >](#)
- [Immunisations >](#)
- [Well baby check >](#)
- [Well person check and screening >](#)

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General organisation and funding of health care in Australia

Australia's health system is a complex interaction of public and private providers and institutions.

Australia was formed by six separate states joining together in a Federation in 1901. Each state had its own form of government and health systems. After Federation, some areas of government remained with the states. These included health and education, resulting in slightly different health delivery systems in each state. There are now also two self-governing territories. Each state and territory remains responsible for hospital care, community and public health, most screening programs and ambulance services.

The formation of the Federation and the enactment of the Constitution further restricted rights for Aboriginal and Torres Strait Islander peoples. For example, the Constitution included legislation that excluded Aboriginal and Torres Strait Islander peoples from federal legislation.

Over time, the Australian Government has become increasingly involved in health care through its funding. The largest change to federal powers was the introduction of a universal health insurance scheme, Medicare, which is funded through taxation. Public hospital care is available at no cost to Australian citizens and permanent residents.

Medicare provides a rebate for consultations and some other services provided outside of hospitals by GPs, care outside of hospitals by medical specialists, and some other health professionals such as optometrists. A significant proportion of GP services and a considerable majority of specialist services are billed to the patient, who must then seek reimbursement of the allowable Medicare rebate. This usually leaves the patient with a residual out-of-pocket cost, which can vary considerably between practitioners. Many hospitals provide specialist outpatient clinics, which incur no cost to patients and are funded through state/territory health funds.

The healthcare system is stratified, with most first-contact care provided by GPs. Patients are encouraged to attend a GP initially. Consultation with other medical specialists is usually by referral from a GP. Patients with urgent or life-threatening problems can access hospital emergency departments without a referral. Consultations with specialists are only reimbursed at the higher specialist rate if a valid referral has been provided by another doctor, usually a GP.

More information is available from the Australian Institute of Health and Welfare and the Australian Government Department of Health, Disability and Ageing [1,2].

Most GPs work in private practices. These practices operate on a fee-for-service model, with the option to 'bulk-bill' the consultation cost directly to Medicare. Bulk-billing means that there is no cost to the patient, and the doctor accepts the government rebate as full payment for the consultation or service delivered. Alternatively, medical practitioners may charge the patient more than the rebate. The patient can then claim a payment from Medicare, which refunds a proportion of the cost. There are also

several community-controlled health services that work on different funding models. The most plentiful of these are Aboriginal community-controlled health services. Some workplaces, including the armed forces, also deliver medical services outside the Medicare funding framework.

Other health funding sources exist. These include programs for motor vehicle accidents and work-related accidents (workers' compensation, which also varies between states and territories). Australians may elect to purchase private insurance to cover costs of admission to private hospitals or for additional services such as dentistry and allied health. There is a variety of other funding sources for specific groups, such as the National Disability Insurance Scheme (NDIS), and doctors working with such groups should be aware of their availability and the rules governing their administration.

Pharmaceutical drugs are approved by the Therapeutic Goods Administration for use in Australia and may then be listed on the Pharmaceutical Benefits Scheme (PBS). The PBS is designed to provide equitable access to medications by capping the amount a patient will pay for a prescription. Not all drugs are listed on the PBS. If a drug approved for use is not listed on the PBS, it may be available by private prescription at full cost to the patient. Some expensive, second-line or restricted-use drugs require specific permission (or 'authority') to prescribe using the PBS. It is important for doctors to understand the PBS and its rules and restrictions [3].

People receiving the age or disability pension, veterans, unemployed people and some other disadvantaged groups have additional 'safety net' provisions that cap their personal out-of-pocket expenditure for services and items covered by Medicare.

See also

- [Equitable access to care >](#)
- [Medication review and prescribing >](#)
- [Resource allocation >](#)

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Practitioner registration

To practise medicine in Australia, a doctor must be registered with the Medical Board of Australia, one of the bodies administered by Ahpra [1]. The Medical Board registers all medical practitioners, provides guidelines for expected practice and responds to complaints and concerns about the performance of practitioners. Registration to practise may be limited or removed if breaches of professional codes are found to have occurred. Fifteen other health professions are also registered by equivalent national boards, supported by Ahpra, and are subject to their own professional standards and codes of conduct. The register of practitioners is a public document that anyone can consult.

A doctor must have registration as a specialist with Ahpra to practise unsupervised and to have their bills recognised and reimbursed by Medicare [2]. In this context, specialists are doctors who meet the criteria for unsupervised practice as determined by the relevant specialty college. In Australia, general practice is one of the recognised fields of specialty practice. Doctors are issued with a unique site-specific provider number by Medicare to allow such payments and to track practice patterns.

Not all services are covered by Medicare. Services covered by workers' compensation and similar schemes should be billed to those schemes. Items such as population screening, medicolegal reports, life insurance medicals and recreational activities such as fitness for flying or diving are excluded from Medicare payment. It is the individual doctor's responsibility to ensure that the appropriate consultation item is billed for a particular service. Medicare Australia conducts audits of practising patterns and provides feedback to practitioners on such data.

See also

- [Continuing professional development >](#)

Useful resource

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.

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Patient presentations

This section of *Australian medicine in context* describes the common symptoms or combinations of symptoms that lead to a patient presenting to the healthcare system. The aim for each topic is to provide some Australian context, and indicate causes that are more common or those that are less common but important not to miss. It also aims to highlight common pitfalls faced by doctors, the diagnoses they might inadvertently overlook and consideration of specific groups that may be affected.

Note: Where applicable, conditions listed under the ‘indicative causes’ section of each presentation correspond to their numbering in the list of conditions at the end of this book (see pages 331–346).

1. Abdominal and loin pain

Overview

Patients presenting with abdominal and loin pain are common in primary care and hospitals. Multiple systems can be implicated, including gastrointestinal, vascular, genitourinary, psychological, musculoskeletal and neurological.

The temporal nature of the problem can aid diagnosis (e.g. acute, chronic, relapsing). The character of the pain (colicky or constant) and associated symptoms can also assist. The cause can vary with the age of the patient and/or the location of the pain (e.g. upper abdomen, lower abdomen, back, right or left side).

Indicative causes

Common

- **Acute**

- 40. Appendicitis
- 76. Biliary atresia or 77. Biliary colic
- 87. Bowel obstruction
- Cystitis
- 185. Diverticular disease
- 247. Gastroenteritis
- Gynaecological or obstetric problem (e.g. 202. Ectopic pregnancy, 211. Endometriosis, 454. Ovarian cyst, 455. Ovarian hyperstimulation syndrome, 456. Ovarian malignancy, 457. Ovarian torsion, 519. Pregnancy)
- 466. Pancreatitis
- 477. Peptic ulcer disease
- 540. Pyelonephritis
- 554. Renal colic
- 649. Trauma
- 661. Urinary retention

- **Chronic**

- 150. Constipation
- 248. Gastrointestinal cancer
- 336. Irritable bowel syndrome
- 425. Non-ulcer dyspepsia
- Psychological (e.g. 596. Somatic symptom disorder)
- 246. Gastro-oesophageal reflux disease

Not so common, though not to miss

- 202. Ectopic pregnancy
- 291. Herpes zoster
- 313. Incarcerated hernia
- 320. Inflammatory bowel disease
- 325. Intra-abdominal abscess
- 389. Mesenteric ischaemia
- 405. Musculoskeletal pain
- 409. Myocardial ischaemia
- 455. Ovarian hyperstimulation syndrome
- 568. Rheumatic heart disease
- Ruptured aortic aneurysm (e.g. 2. Abdominal aortic aneurysm, 32. Aortic aneurysm, 34. Aortic dissection)
- 642. Torsion of ovary or adnexae

Key considerations

- Associated symptoms (e.g. altered bowel habit, nausea, vomiting or fever) can assist with diagnosis
- Be aware of drug- or attention-seeking
- Evidence of sepsis and/or hypovolaemia indicate urgency for diagnosis and management
- For acute pain, it is important to form an initial decision regarding how serious the condition might be, as patients can quickly deteriorate

Common pitfalls

- Not considering causes beyond the gastrointestinal tract or beyond the abdominal cavity
- Not considering pregnancy among women of reproductive age

Consideration of specific groups

- Chronic recurrent abdominal pain among children
- Intussusception or malrotation with volvulus among children
- Ischaemia may present at younger ages in Aboriginal and/or Torres Strait Islander people
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Testicular torsion among boys
- Urinary tract infection among children

See also

- [Abdominal swelling, lump and bloating >](#)
- [Altered bowel function >](#)
- [Childbirth >](#)
- [Jaundice >](#)
- [Pelvic pain >](#)
- [Pregnancy >](#)
- [Preterm labour >](#)

2. Abdominal swelling, lump and bloating

Overview

Physical examination helps determine the nature and extent of abdominal swelling, lump and bloating, and whether the location is within the gastrointestinal system or arising from other sites (e.g. the abdominal wall or the pelvis).

Indicative causes

Common

- 3. Abdominal hernia, 321. Inguinal hernia or 314. Incisional hernia
- 150. Constipation
- Enlarged liver (e.g. 355. Liver disease)
- 327. Intra-abdominal or pelvic malignancy
- 336. Irritable bowel syndrome
- 427. Obesity
- 454. Ovarian cyst or 456. Ovarian malignancy (e.g. tumour)
- 519. Pregnancy
- 664. Uterine fibroids

Not so common, though not to miss

- 2. Abdominal aortic aneurysm
- 5. Abscess
- 47. Ascites
- 87. Bowel obstruction
- Distended bladder (e.g. 661. Urinary retention)
- 184. Divarication of the rectus muscles
- Enlarged kidney(s) (e.g. 507. Polycystic kidney[s])
- 603. Splenomegaly
- 326. Intra-abdominal haemorrhage
- 455. Ovarian hyperstimulation syndrome

Key considerations

- Consider ovarian cancer among otherwise well women, or women with non-specific mild symptoms (e.g. bloating)
- Consider the appropriate imaging modality (e.g. ultrasound, rather than computed tomography [CT], is often better for gynaecological problems and biliary disease)

Common pitfalls

- Missing common benign causes (e.g. irritable bowel syndrome, pregnancy)
- Not examining outside the abdomen (e.g. heart, lymph node groups)

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are at greater risk from undiagnosed infectious causes
- Constipation among children or older people
- Kwashiorkor in severely disadvantaged and remote Aboriginal and/or Torres Strait Islander communities
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Splenomegaly from tropical illnesses among Aboriginal and/or Torres Strait Islander peoples, those living in tropical areas of Australia, and migrant groups

See also

- [Abdominal and loin pain >](#)
- [Childbirth >](#)
- [Nausea and vomiting >](#)
- [Pregnancy >](#)
- [Preterm labour >](#)

3. Abnormal heart sounds and murmurs

Overview

Although a patient may not present with abnormal heart sounds or murmurs, they can be common incidental findings. Abnormal heart sounds are clues to underlying disease. The most common abnormalities among adults are mitral regurgitation, aortic stenosis and tricuspid regurgitation; the most common abnormality among infants is a ventricular septal defect. A diastolic murmur almost always indicates disease. Systolic murmurs are common and may be benign.

Indicative causes

Common systolic murmurs

- Acquired heart disease
 - 36. Aortic stenosis (e.g. calcified bicuspid valve, rheumatic valve disease)
 - 395. Mitral regurgitation (e.g. 282. Dilated cardiomyopathy, 666. Valve ring or chordae abnormality)
 - 651. Tricuspid regurgitation (e.g. 282. Dilated cardiomyopathy, 537. Pulmonary hypertension)
- 147. Congenital heart disease
 - Septal defects
- Innocent murmur

Common diastolic murmurs

- 35. Aortic regurgitation (e.g. 301. Hypertension, 568. Rheumatic heart disease)
- 396. Mitral stenosis (e.g. 568. Rheumatic heart disease)

Not so common, though not to miss

- 35. Aortic regurgitation (e.g. 376. Marfan syndrome, 183. Dissecting aneurysm, 140. Collagen vascular disease)
- 65. Bacterial endocarditis
- 147. Congenital heart disease
 - Cyanotic heart disease (e.g. 225. Fallot tetralogy, 648. Transposition of the great arteries)
 - 472. Patent ductus arteriosus
 - 539. Pulmonary valve abnormality
- 567. Rheumatic fever and/or 568. Rheumatic heart disease
- 667. Valve rupture

Key considerations

- Bacterial endocarditis prophylaxis may be required before some medical and dental procedures
- Bicuspid aortic valve disease is often associated with a dilated ascending aorta
- Differential diagnosis depends on which heart sound is abnormally loud or abnormally soft, and whether the murmur is systolic or diastolic
- Extra heart sounds and murmurs can be normal among children
- For non-innocent murmurs, obtain electrocardiogram (ECG), chest X-ray and echocardiogram
- Murmurs can also be caused by non-valvular conditions including hyperdynamic states (e.g. flow murmur of pregnancy)
- Significant rheumatic heart disease can be present without an audible murmur
- Widespread use of antenatal ultrasound has resulted in most serious cardiac malformations being detected before birth

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people have high rates of rheumatic and ischaemic heart disease
- People with a history of using intravenous drugs are at risk of endocarditis
- Significant murmurs may not appear until after the first week of life

See also

- [Difficulty breathing—shortness of breath >](#)
- [Failure to thrive >](#)
- [Faintness and collapse >](#)

4. Abnormal thoughts and perceptions

Overview

Abnormal thoughts and perceptions can occur in psychosis as part of mental illness.

Formal thought disorder is an abnormality of:

- continuity of thinking—whether goal-directed, relevant or irrelevant, loose associations, illogical, tangential, circumstantial, evasive, perseverative, blocking or distractible
- language impairment—incoherent or incomprehensible speech ('word salad'), clang associations or neologisms
- productivity of thinking—overabundance or paucity of ideas, flight of ideas, hesitant thinking, rapid/slowed thinking, impaired stream of thought or lack of spontaneity.

Disturbances of the content of thinking include preoccupations, obsessions, phobias, hypochondriacal thoughts, delusions, ideas of reference, thought broadcasting and thought insertion.

Delusion is a fixed bizarre abnormal belief that is inconsistent with the individual's culture. There are various types (e.g. persecutory, grandiose, religious/spiritual, somatic, nihilistic/catastrophic, and referential). The delusion most characteristic of schizophrenia is a passivity phenomenon where a person is no longer in control of their thoughts, feelings or will, and they are being influenced or controlled by some mysterious alien force.

A hallucination is an abnormal perception without a stimulus. Auditory hallucinations in the form of voices are the most common. Visual, olfactory, gustatory and tactile hallucinations are all rare in the absence of hallucinatory voices. The voices may be external—coming from the environment—or internal—a silent voice coming from within the mind, which is insistent, troublesome or frightening. Command hallucinations may be mundane (e.g. 'stand up', 'go outside', 'wash your hands') or they may order the person to harm themselves or others.

Indicative causes

Common

- 18. Alcohol or recreational drug use or withdrawal
- 166. Delirium
- 174. Depression with psychosis
- 375. Mania and hypomania
- 577. Schizophrenia

Not so common, though not to miss

- 167. Dementia, particularly with 164. Lewy bodies
- 86. Borderline and/or antisocial personality disorder
- Organic brain disease (e.g. 208. Encephalitis, 88. Brain injury, 469. Parkinson disease, 392. Migraine, 218. Epilepsy)
- 189. Drug side effects (prescribed medication)

Key considerations

- Command hallucinations that an individual cannot resist increase the risk of harm to self or others
- Hallucinations may also occur in sleep deprivation, grief and the onset of and waking from sleep

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may experience thoughts or perceptual phenomena that are specific to their spiritual and cultural beliefs, and therefore these may be culturally appropriate
- Some women experience postpartum psychosis

See also

- [Anxiety >](#)
- [Mood dysfunction >](#)
- [Substance misuse and addiction >](#)

5. Acutely unwell infant

Overview

An acutely unwell infant may present with pallor and hypotonia, with or without otherwise non-specific features. There is a wide range of potentially serious causes and these vary with the age and sex of the child.

Indicative causes

Common

- 51. Asthma
- 247. Gastroenteritis
- Hypoglycaemic seizures (e.g. 218. Epilepsy, 305. Hypoglycaemia)
- Respiratory infection (e.g. 96. Bronchiolitis, 318. Infection [bacterial, viral, fungal], 358. Lower respiratory tract infection, 656. Upper respiratory tract infection, 97. Bronchitis)
- 583. Sepsis

Not so common, though not to miss

- 41. Arrhythmias, especially 619. Supraventricular tachycardia
- 145. Congenital adrenal hyperplasia
- 147. Congenital heart disease (e.g. 33. Aortic coarctation)
- 312. Inborn errors of metabolism
- 332. Intussusception
- 423. Non-accidental injury or physical abuse
- 663. Urinary tract infection

Key considerations

- Expert assistance should always be sought
- Hypoglycaemia and/or metabolic acidosis can be associated with many of the causes, and do not necessarily indicate an inborn error of metabolism
- Serious overwhelming infection can be present without a fever

Consideration of specific groups

- Babies younger than 3 months are the most likely to have serious disease
- Dehydration with gastroenteritis among young children
- Specific consulting skills and/or transfer to another healthcare facility are required for Aboriginal and/or Torres Strait Islander infants, as outlined in [Aboriginal and Torres Strait Islander views of health](#)

See also

- [Febrile child >](#)
- [Irritable infant >](#)

6. Altered bowel function

Overview

Presentation with altered bowel function includes alteration in frequency, consistency, control and/or content of the bowel motions. Examples include constipation, diarrhoea, steatorrhoea, faecal incontinence, pus or mucus with the bowel motions and/or pain on defaecation. Rectal bleeding raises other diagnostic possibilities.

The temporal nature of the problem (e.g. acute, chronic, relapsing) and associated symptoms can assist diagnosis.

Indicative causes

Common

- 247. Gastroenteritis
- 248. Gastrointestinal cancer
- 150. Constipation (fibre, fluid intake and/or inactivity is a risk factor for constipation)
- 336. Irritable bowel syndrome
- 189. Drug side effects of prescribed or over-the-counter medications (e.g. laxatives, opioids, anticholinergic agents, antipsychotics, antidepressants)

Not so common, though not to miss

- 189. Drug side effects (e.g. alternative medicine, bush medicine)
- 139. Coeliac disease
- 154. Cow's milk protein intolerance among children
- 211. Endometriosis
- 306. Hypothyroidism
- 338. Ischaemic colitis
- 320. Inflammatory bowel disease
- 237. Food intolerance (e.g. lactose)
- 366. Major depressive disorder
- 460. Overflow diarrhoea secondary to faecal impaction
- 465. Pancreatic insufficiency

Key considerations

- Associated symptoms (e.g. melaena, nausea, vomiting, fever) raise other diagnostic possibilities
- Chronic laxative misuse can manifest as constipation
- Complicating malabsorption can be missed
- Fibre supplements without adequate hydration can result in constipation
- Gastrointestinal cancers can occur in young adults
- Review prescribed and over-the-counter medications

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander children are at higher risk of complications from gastroenteritis
- Constipation from low activity and restrictive diet (e.g. in occupants of residential care facilities)
- Overseas travellers
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

See also

- [Abdominal swelling, lump and bloating >](#)
- [Nausea and vomiting >](#)
- [Pelvic pain >](#)
- [Rectal bleeding and pain >](#)

7. Altered level of consciousness

Overview

When presenting with an altered level of consciousness, the patient is usually unable to provide a history, so information from eyewitnesses and people who know the patient is vital. Protection of the airway and prevention of other injuries should be considered.

Indicative causes

Common

- Cardiac arrhythmia (41. Arrhythmias, 682. Ventricular tachyarrhythmias)
- 119. Cerebrovascular disease or cerebral injury
- 218. Epilepsy
- 279. Head injury
- Metabolic disorders
 - 181. Diabetic ketoacidosis
 - 305. Hypoglycaemia
 - 657. Uraemia
- 615. Substance use (e.g. alcohol, analgesics, illicit drugs, sedatives)
- 679. Vasovagal or vasodepressor syncope

Not so common, though not to miss

- Encephalopathy (e.g. 293. Hypertensive, 356. Liver failure [hepatic], 16. Alcohol excess)
- 307. Hypoxia (e.g. 536. Pulmonary embolism, 505. Poisoning)
- Infection (e.g. 386. Meningitis, 208. Encephalitis, 583. Systemic sepsis)
- 543. Raised intracranial pressure (e.g. tumour, haemorrhage)
- Psychological (e.g. 152. Conversion disorder, 223. Factitious disorder, 371. Malingering)

Key considerations

- Be sure to gather third-party reports (collateral history)

Common pitfall

- Assuming intoxication before other causes have been excluded

Consideration of specific groups

- Young children may accidentally ingest poisons or other dangerous substances

See also

- [Bites and stings >](#)
- [Faintness and collapse >](#)
- [Poisoning >](#)
- [Seizures and convulsions >](#)

8. Altered vision

Overview

Altered vision includes decreased visual acuity, floaters and flashes, light sensitivity and double vision. Patients with disorders of eye movement usually present with diplopia. Light sensitivity usually indicates corneal or uveal irritation or intracranial problems (e.g. migraine). Flashes, and sometimes floaters, indicate retinal disease, and may require urgent expert assessment. Chronic and/or slow onset decreased visual acuity is common and can indicate refractive error, cataracts, glaucoma, or retinal or vitreous disease.

Indicative causes

Common

- 109. Cataracts
- 365. Macular degeneration
- 392. Migraine
- 551. Refractive errors
- 563. Retinopathy (e.g. diabetic, hypertensive)

Not so common, though not to miss

- 119. Cerebrovascular disease or cerebral injury
- 259. Glaucoma
- 546. Recreational drug excess (hallucinogen use)
- 328. Intra-ocular or intracranial malignancies
- 560. Retinal detachment (posterior vitreous)
- 518. Preeclampsia
- 562. Retinoblastoma in an infant
- 561. Retinitis
- 626. Temporal arteritis
- 646. Trachoma
- 649. Trauma

Key considerations

- Absent red reflex in the newborn requires urgent assessment for congenital cataracts or retinoblastoma
- Consider any impact on function (e.g. childhood development) and safety (e.g. driving)
- Establishing which part of the visual pathway is affected (e.g. lens, retina, optic nerve, visual cortex) will assist diagnosis

- Once restrictive disease or myasthenia gravis is excluded, the major cause of binocular diplopia is a cranial nerve lesion
- The timeframe of decreased vision can assist diagnosis; acute changes require urgent assessment
- Untreated glaucoma can lead to irreversible damage to vision

Common pitfalls

- Not examining both eyes with an ophthalmoscope
- Not exploring beyond one system
- Not testing the patient's vision

Consideration of specific groups

- People with diabetes mellitus, as this condition can affect several parts of the visual pathway
- Trachoma is endemic in some remote areas of Australia, particularly affecting Aboriginal and/or Torres Strait Islander people, and is the primary cause of preventable blindness

See also

- [Eye—red or painful >](#)
- [Eye—swollen or discharging >](#)

9. Anxiety

Overview

Anxiety is common. Diagnostically, it is important to distinguish between a normal variation of worry and an anxiety disorder. Anxiety may be associated with comorbid conditions (e.g. personality disorder; depression; psychotic disorder; misuse of alcohol, benzodiazepines and other substances).

Anxiety disorders are characterised by excessive and persistent worry, apprehension or fear occurring on most days over a prolonged period. The anxiety is often associated with restlessness, difficulty concentrating, being easily fatigued, muscle tension and sleep disturbance. These symptoms may cause significant distress or impairment in social, occupational and/or personal functioning.

Frequently, patients present with predominantly somatic symptoms—either a single complaint (e.g. chest pain, neurological deficit) or a large number of multisystem symptoms through the process of somatisation.

Indicative causes

Common

- 12. Acute stress disorder
- 13. Adjustment disorder
- 172. Depression
- 191. Drug withdrawal or 18. Alcohol withdrawal
- 167. Dementia
- 252. Generalised anxiety disorder
- 428. Obsessive–compulsive disorder
- 467. Panic disorder
- 514. Post-traumatic stress disorder
- 495. Phobia (e.g. school phobia or refusal)
- 582. Separation anxiety disorder
- 595. Social anxiety disorder

Not so common, though not to miss

- 14. Agoraphobia
- 57. Autism spectrum disorder
- 84. Body dysmorphic disorder
- 251. Gender dysphoria
- 302. Hyperthyroidism
- 329. Intracranial lesions and bleeds

- 470. Personality disorder
- 545. Reactive attachment disorder

Key considerations

- Anxiety and depressive symptoms often coexist, so it is important to distinguish between anxiety disorders and depressive disorders
- Anxiety disorders are a risk factor for suicidal ideation and death by suicide
- Avoidance symptoms are often not reported, but cause significant impairment in social and occupational functioning

Common pitfalls

- Dismissing the possibility of physical illness as an explanation for somatic symptoms, or the possibility that physical illness may coexist with somatic symptoms of anxiety
- Misinterpreting hypervigilance as a psychotic symptom
- Missing a diagnosis of anxiety disorder

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people can be at greater risk of anxiety due to the effects of colonisation and systemic racism
- Asylum seekers and refugees
- Children who have experienced trauma, abuse, neglect and/or bullying
- Military personnel and first responders
- People with chronic physical illnesses (e.g. asthma, cardiac disease)
- Spiritual and cultural beliefs may affect how anxiety presents
- Survivors of natural disasters and civil conflict

See also

- [Abnormal thoughts and perceptions >](#)
- [Mood dysfunction >](#)

10. Back and neck pain

Overview

Back and neck pain are common and a major burden of disease. Most lower back pain is of benign aetiology, with spontaneous recovery over the course of days or weeks. Persisting or worsening pain requires further assessment.

The most common spinal fractures are wedge/crush fractures of vertebral bodies due to osteoporosis or malignancy. Spinal cord injuries most often result from trauma.

Indicative causes

Common

- 405. Musculoskeletal pain (e.g. degenerative, disc disease and prolapse, soft tissue injury, non-specific back or neck pain)
- 600. Spinal canal stenosis
- Vertebral fracture (e.g. 449. osteoporosis, 649. trauma, 370. malignancy)

Not so common, though not to miss

- 110. Cauda equina compression
- Inflammatory conditions (e.g. 28. Ankylosing spondylitis)
- 391. Metastatic malignancy
- 519. Pregnancy
- Referred pain (e.g. 466. Pancreatitis, 2. Abdominal aortic aneurysm)
- 596. Somatic symptoms of a mental illness
- 599. Spinal abscess
- 649. Trauma

Key considerations

- Consider modified occupational activities to facilitate early return to work and remaining active
- Promoting self-management is an important step in recovery
- There is often a poor association between the symptoms and changes detected on imaging

Common pitfalls

- Inappropriate use of imaging
- Not instituting conservative management strategies and allied health referral (e.g. physiotherapy)

- Not recognising associated neurological symptoms (including loss of bladder or bowel control)
- Not recognising that upper limb symptoms (e.g. digital paraesthesia) can be secondary to cervical spine disease
- Overprescription of pain relief medications

Consideration of specific groups

- People whose occupations involve heavy lifting, prolonged sitting or other risk factors (e.g. manual labourers, carers, office-based workers, athletes)

See also

- [Bone pain >](#)
- [Muscle or soft tissue pain >](#)

11. Bad breath

Overview

Conditions of the mouth may be diagnosed and managed by dental and/or medical practitioners. Bad breath (halitosis) can reflect local problems with the teeth, gums or tongue, or it can be a marker of systemic disease.

Indicative causes

Common

- Coated tongue
- 170. Dental caries
- 246. Gastro-oesophageal reflux disease
- Infection (e.g. 103. Candidiasis)
- Mouth breathing
- 482. Periodontal disease
- 589. Sinusitis
- 593. Sleep apnoea
- 639. Tonsillitis

Not so common, though not to miss

- 87. Bowel obstruction
- 150. Constipation/faecal impaction
- Foreign body in nose (e.g. 238. Foreign body aspiration, 239. Foreign body trauma)
- 359. Lung abscess
- Metabolic disorders (e.g. 555. Renal failure, 7. Acidosis, 355. Liver disease)
- 492. Pharyngeal pouch

Key considerations

Common pitfalls

- Missing a metabolic cause (e.g. diabetic ketoacidosis)
- Not seeking a cause (e.g. nutritional deficiency causing glossitis)
- Not considering inhaled steroid use or technique
- Not referring when dental care is required

See also

- [Dry mouth >](#)

12. Behavioural problem in childhood

Overview

Behavioural problems in childhood are common and can be part of the normal spectrum of behaviour and development. It is important to identify behavioural problems that may be responsive to treatment.

Indicative causes

Common

- 56. Attention deficit hyperactivity disorder
- 57. Autism spectrum disorder
- Normal variations in behaviour
- 438. Oppositional defiance disorder

Not so common, though not to miss

- Domestic violence, abuse and neglect
- 323. Intellectual disability
- Vision or hearing impairment

Key considerations

Common pitfalls

- Failure to assess development and cognition
- Failure to assess hearing and vision

Consideration of specific groups

- Children with coexistent illnesses may be at higher risk of behavioural problems

See also

- [Developmental abnormality >](#)
- [Domestic violence, abuse and neglect >](#)
- [Irritable infant >](#)

13. Bites and stings

Overview

In Australia, bites and stings can be inflicted by a wide range of animals including insects, spiders and other arthropods; jellyfish (e.g. box jellyfish, Irukandji); blue-ringed octopuses; snakes; dogs; crocodiles; several venomous fish; and sharks. Although most bites cause minor irritation, some can cause serious medical complications and can be a vector for infectious agents.

Consider these indicative complications

Common complications

- **Bites**
 - Infected bite sites
 - Infectious agent transmission (e.g. 322. Insect-borne viruses, 361. Lyme disease, 368. Malaria)
 - 214. Envenomation including toxic reaction
 - 138. Coagulopathy
 - 273. Haemolysis
- **Stings**
 - 19. Allergic reaction
 - Local reaction and pain

Not so common complications, though not to miss

- 24. Anaphylaxis

Key considerations

- First aid and/or evacuation should be initiated promptly and will depend on what caused the bite
- Knowledge of potential long-term complications is needed; Therapeutic Guidelines (<https://www.tg.org.au>), CSL Seqirus (<https://www.cslseqirus.com.au/expertise/antivenom-and-q-fever-vaccines/australian-bites-and-stings>) and state- and territory-based poisons information centres have useful information
- Some envenomations have specific antivenom treatments (e.g. some snake and spider bites), so it is important to identify what caused the bite
- Use of prophylactic antibiotics and tetanus immunisation will depend on what caused the bite

Common pitfalls

- Delay in administering antivenom
- Delay in treating anaphylaxis
- Not considering venomous causes or species

See also

- [Cardiopulmonary arrest >](#)
- [Faintness and collapse >](#)

14. Bleeding gums

Overview

Conditions of the mouth may be localised or reflect a systemic condition. They may be diagnosed and managed by dental and/or medical practitioners.

Indicative causes

Common

- 189. Drug side effects (chemotherapy)
- 257. Gingivitis

Not so common, though not to miss

- 81. Bleeding disorders (e.g. 185. Anticoagulant therapy, 688. Von Willebrand disease)
- 352. Leukaemia
- 635. Thrombocytopaenia or platelet dysfunction
- 649. Trauma
- 687. Vitamin C deficiency

Key considerations

Common pitfalls

- Misdiagnosis or inadequate assessment
- Not referring for dental care if required

Consideration of specific groups

- People who misuse alcohol or other drugs
- Pregnant women

See also

- [Bruising >](#)
- [Mouth or throat problem >](#)
- [Toothache >](#)

15. Bone pain

Overview

Bone pain among children is commonly related to 'growing pains', which are ill-defined but benign. Bone pain among adults is often referred pain from joints. Among children and adults, bone pain can also be the first manifestation of significant underlying disease.

Indicative causes

Common

- 85. Bone bruising or 484. Periosteal bruising
- Fracture
- 1. 'Growing pains' among children
- 444. Osteochondritis during puberty (e.g. 442. Osgood–Schlatter disease)
- Referred pain from joints

Not so common, though not to miss

- 352. Leukaemia or 401. Multiple myeloma
- 391. Metastatic malignancy
- 447. Osteomyelitis
- 450. Osteosarcoma
- 463. Paget disease
- 687. Vitamin D deficiency/osteomalacia

Key considerations

- Reasons for investigation include acute onset, symptoms worsening over time, avoiding weight-bearing, local tenderness, pain that wakes at night or associated fever

Consideration of specific groups

- Children who are hesitant or who refuse to walk
- Individuals at risk of vitamin D deficiency
- Oncology and immunology patients receiving cytokine therapy

See also

- [Back and neck pain >](#)
- [Joint problem >](#)
- [Muscle or soft tissue pain >](#)

16. Breast lump, pain and discharge

Overview

Although most breast lumps are benign, breast cancer is the most common cancer among women, and a painless lump is a common initial presentation. Breast pain can be associated with the menstrual cycle or the combined oral contraceptive pill. Infection should be considered when there is pain, redness, discharge or an associated fever.

Indicative causes

Common

- 92. Breast cancer
- 93. Breast cyst
- 231. Fibroadenoma
- Mastalgia from hormonal fluctuations
- 378. Mastitis

Not so common, though not to miss

- 91. Breast abscess
- 526. Prolactinoma
- Medication-related 270. Gynaecomastia, mastalgia and/or 243. Galactorrhoea

Key considerations

- Blood-stained discharge requires investigation
- Breast cancer is the most important diagnosis to exclude
- Breast cancer can also occur among men
- Diagnostic approach may need to be altered for people who have had breast augmentation surgery

Consideration of specific groups

- Adolescent boys can develop transient gynaecomastia
- Both male and female newborn infants can develop breast enlargement and galactorrhoea in the first week of life as a result of residual maternal hormones
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

17. Breastfeeding problem

Overview

In Australia, breastfeeding is encouraged because of the health benefits to the child and enhancement of the mother–child bond.

Indicative causes

Common

- 94. Breast engorgement
- 155. Cracked nipples
- Inadequate milk production
- 333. Inverted nipples
- 378. Mastitis
- Poor infant attachment
- 31. Anxiety and/or 172. Depression

Not so common, though not to miss

- 91. Breast abscess
- 197. Dysphoric milk ejection reflex

Key considerations

- Check adequacy of infant weight gain
- Consider contraindications to breastfeeding, including infective causes (e.g. active tuberculosis, HIV in some situations) and medications (e.g. radioactive iodine)
- Culturally appropriate support is needed to support initiation and continuation of breastfeeding

Common pitfalls

- Giving advice that undermines the mother's confidence
- Not arranging expert advice and assistance

Consideration of specific groups

- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#) and [Aboriginal and Torres Strait Islander views of health](#)

See also

- [Failure to thrive >](#)
- [Feeding problem in a child >](#)
- [Irritable infant >](#)

18. Bruising

Overview

Most causes of bruising are self-evident and proportionately related to an injury. However, in other cases, bruising may reflect systemic disease. A bleeding tendency can manifest with cutaneous and/or systemic features.

Indicative causes

Common

- 189. Drug side effects (e.g. anticoagulants, antiplatelet agents and other medications, such as steroids)
- Capillary fragility among older people
- 355. Liver disease
- 649. Trauma

Not so common, though not to miss

- 352. Leukaemia, 401. Multiple myeloma or haematological malignancy (e.g. 364. Lymphoma)
- 275. Haemophilia
- 286. Henoch–Schönlein purpura
- 423. Non-accidental injury (abuse)
- 635. Thrombocytopaenia or platelet dysfunction
- Toxins (e.g. snake bite)
- 678. Vasculitis

Key considerations

- Consider non-accidental injury if there is unexplained, repetitive bruising or bruises of mixed ages
- Hyperpigmentation can sometimes be mistaken for bruising
- Many cases can be investigated with full blood count and coagulation profile
- Patients with a bleeding disorder often initially present with pain due to internal bleeding

Common pitfall

- Not recognising over-the-counter medication as a cause of bleeding

Consideration of specific groups

- Children, people with disabilities and older people are at higher risk of non-accidental injury

See also

- [Bleeding gums >](#)

19. Burns and scalds

Overview

It is important to determine the mechanism, depth, site and extent of a burn or scald, as this informs management and risk of complications.

Indicative causes

- Chemical corrosives
 - Acids (e.g. from workplaces, pool chemicals)
 - Alkalis (e.g. household cleaning agents, dishwashing powders)
- Electrical (including lightning)
- Flames (e.g. household fires, candles, cigarettes)
- Hot liquids (e.g. kettles, baths, fat)
- Stoves, ovens and barbecues
- Sunburn

Key considerations

- Electrical burns also cause damage at the earthing point and in non-visible structures (muscles, internal organs)
- Implement early first aid and resuscitation
- Referral or urgent transfer to burns unit will depend on:
 - age, particularly children
 - anatomical location (e.g. face, genitalia, joints)
 - depth of burn
 - risk to airway
 - surface area affected
- Preventive measures should be instigated, particularly in the workplace and cooking areas
- Sunburn can sometimes be severe enough to require fluid resuscitation
- The relevant state- or territory-based poisons information centre can provide advice regarding chemical burns

Consideration of specific groups

- People who are intoxicated with alcohol or other substances
- People with disabilities, families with young children, and older people
- People with epilepsy
- Vulnerable groups, including people experiencing homelessness and those without adequate heating, are at particular risk

See also

- [Poisoning >](#)

20. Calf, thigh and buttock pain on walking

Overview

Pain of the calf, thigh or buttock may be vascular, neurogenic or musculoskeletal in origin. Claudication is pain in the calf, thigh and/or buttock on walking or running and is usually caused by occlusive arterial disease; the pain typically resolves with rest.

Indicative causes

Common

- 207. Embolism
- Localised musculoskeletal injury
- 443. Osteoarthritis
- 43. Arterial insufficiency
- 578. Sciatica

Not so common, though not to miss

- 32. Aortic aneurysm
- Autoimmune disorders (e.g. 45. Arteritis)
- Conditions that cause accelerated 52. Atherosclerosis
- 164. Deep vein thrombosis
- 234. Fibromuscular disease
- 600. Spinal canal stenosis

Key considerations

- For arterial vascular causes:
 - consider concomitant cardiovascular disease, especially coronary artery disease
 - include a thorough examination for pulses and bruits, from aorta to periphery
 - pain at rest is an advanced symptom

Common pitfall

- Failure to consider more than one system

Consideration of specific groups

- Ischaemia may present at younger ages in Aboriginal and/or Torres Strait Islander people

See also

- [Bone pain >](#)
- [Gait disturbance >](#)
- [Joint problem >](#)
- [Muscle or soft tissue pain >](#)

21. Cardiopulmonary arrest

Overview

Most cases of cardiac arrest occur secondary to a cardiac arrhythmia. The ability to perform and manage cardiopulmonary resuscitation is essential for all medical practitioners.

Indicative causes

- **Cardiac**
 - 41. Arrhythmias
 - 106. Cardiac rupture or 677. Vascular rupture
 - Electrocutation
 - 676. Vascular occlusion
- Drugs and poisoning (e.g. carbon monoxide, illicit drugs, medications associated with arrhythmias or other heart abnormalities)
- **Neurogenic**
 - 89. Brainstem compression
 - 610. Stroke
- **Pulmonary**
 - 15. Airway obstruction or 49. Aspiration
 - 51. Asthma
 - Drowning
 - 307. Hypoxia
 - 631. Tension pneumothorax

Key considerations

- Be competent and confident in managing a cardiorespiratory arrest
- Identify and interpret signs of impending cardiac and/or respiratory arrest
- Treat likely causes promptly
- Resuscitation relies on effective team training and functioning

Consideration of specific groups

- Ischaemia may present at younger ages in Aboriginal and/or Torres Strait Islander people
- People with chronic obstructive lung disease who use oxygen therapy
- People with known heart disease (e.g. arrhythmias, impaired ejection fraction, hypertrophic cardiomyopathy)

See also

- [Faintness and collapse >](#)
- [Trauma—physical >](#)

22. Chest discomfort and pain

Overview

Chest pain may be central or peripheral. Central chest pain is a common symptom of cardiac disease, but it may also be due to problems in the gastrointestinal, respiratory or musculoskeletal systems, or may be psychogenic in origin.

Angina is the cardinal symptom of ischaemic heart disease.

Indicative causes

Common

- **Cardiac**
 - 339. Ischaemic heart disease (e.g. 25. Angina, 409. Myocardial ischaemia)
- **Chest wall**
 - 153. Costochondritis
 - 405. Musculoskeletal pain (e.g. fractured rib, exercise-related pain ['stitch'])
- **Gastrointestinal**
 - 77. Biliary colic
 - 245. Gastritis or 435. Oesophagitis
 - 246. Gastro-oesophageal reflux disease
 - 292. Hiatus hernia
 - 432. Oesophageal cancer
- Psychogenic (e.g. 31. Anxiety)
- **Pulmonary**
 - 501. Pleuritis
 - 503. Pneumonia

Not so common, though not to miss

- 34. Aortic dissection
- 207. Embolism
- Epigastric pain associated with 518. Preeclampsia
- 291. Herpes zoster
- 360. Lung malignancy (cancer)
- 480. Pericarditis (infective or non-infective)
- **Pulmonary**
 - 504. Pneumothorax

Key considerations

- Recognise features that require prompt intervention (e.g. crescendo angina)
- Some conditions (e.g. diabetes, neuropathies) can dampen perception of chest pain

Common pitfalls

- Not considering cardiac cause among women and ‘fit and apparently healthy’ people
- Not considering pulmonary embolism
- Not considering systems other than cardiac

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people have a high burden of ischaemic heart disease
- Ischaemia may present at younger ages in Aboriginal and/or Torres Strait Islander people
- People who use recreational or illicit drugs (e.g. cocaine, amphetamines) are at higher risk of coronary artery disease

See also

- [Indigestion and heartburn >](#)

23. Chest injury

Overview

Injury to the chest may be blunt or sharp. The mechanism or cause of the injury will provide insight into potential problems. Such injuries can be complicated by chest wall bruising or laceration, rib fractures, haemopneumothorax, lung contusion, flail chest, diaphragm rupture or splenic damage. Less common complications include cardiac tamponade, aortic rupture, myocardial trauma, or injuries to the oesophagus, spine or root of neck.

Indicative causes

Common

- Falls
- Household injuries
- Motor vehicle accident

Not so common, though not to miss

- Blast injuries
- Knife or bullet
- Self-harm

Key considerations

Common pitfall

- Aortic or cardiac injury associated with crush injuries can be missed because there may be no localising symptoms

Consideration of specific groups

- Construction, mining and farm workers

See also

- [Trauma—physical >](#)

24. Childbirth

Overview

The onset of labour can be spontaneous or induced. Pregnant women should be aware of the early signs of labour so they can present in a timely manner. Although most women will birth at term (37–42 completed weeks of pregnancy), women with symptoms of preterm labour must be assessed promptly.

The doctor, midwife and other health professionals work as a team to care for the mother and her support person (or people) during childbirth. Decisions about where the baby is to be born, monitoring required during labour and mode of delivery depend on maternal and fetal factors.

The intensity of pain, length of labour and mode of delivery contribute to an emotional time for everyone. Pregnant women should be encouraged to formulate a birth plan, including consideration of analgesia.

Modes of delivery

- Caesarean section (e.g. emergency, elective; prior to labour, during labour)
- Instrumental (forceps- or vacuum-assisted delivery)
- Spontaneous vaginal delivery

Key considerations

- Antenatal care is often shared between a doctor and midwife
- Doctors should be aware of potential complications and the need for additional monitoring and vigilance. These include:
 - cord prolapse
 - fetal distress
 - intrapartum or postpartum haemorrhage
 - malpresentation
 - meconium-stained liquor
 - prolonged labour
 - retained or incomplete placenta
 - shoulder dystocia
- For cultural, religious or personal reasons, some women may request female attendants

Consideration of specific groups

- Cultural and religious groups (e.g. cultures that practise female genital mutilation, Jehovah's Witnesses)
- Obesity is associated with increased risks in childbirth
- Women experiencing precipitous labour
- Women with a concealed pregnancy

See also

- [Preterm labour >](#)

25. Choking

Overview

Choking refers to partial or complete blockage of the airway. This can be due to food, respiratory secretions, foreign bodies or vomitus. People may have the sensation of choking as a symptom of anxiety, panic disorder or conversion disorder. Choking can be an emergency and urgent assessment is essential.

Indicative causes

Common

- Food including bones, seeds, nuts
- 246. Gastro-oesophageal reflux disease
- Secretions

Not so common, though not to miss

- Assault
- 58. Autoerotic asphyxiation
- Ingestion of coins and batteries by children

Key considerations

- Be familiar with current emergency management for choking among adults and children
- Consider comorbid neurological, respiratory and musculoskeletal conditions that make coughing difficult
- Not all patients with a sensation of choking require emergency treatment

Consideration of specific groups

- Children and older people are particularly at risk
- People who are intoxicated with alcohol
- People who have had brain injuries that cause dysphagia (e.g. stroke, dementia)

See also

- [Difficulty breathing—wheezing or noisy breathing >](#)
- [Difficulty swallowing >](#)
- [Faintness and collapse >](#)
- [Foreign body—orifice >](#)

26. Confusion and altered mental state

Overview

Confusion is a disturbance of consciousness that manifests with disorientation in time, place and/or person. When evaluating memory problems, consider the onset, severity, duration, extent and course. Obtaining collateral history is an essential part of the assessment process. Dementia is the most common cause of progressive memory problems.

It is important to identify reversible causes of confusion, particularly depression (which can appear as pseudodementia) and delirium.

Delirium usually indicates significant coexisting acute illness, and patients present with a disturbance of consciousness, perceptual disturbances and cognitive impairment with reduced ability to focus, or sustain or shift attention. This disturbance is likely to develop over a short period (hours to days) and tends to fluctuate throughout the day. It is often associated with disturbance of both the sleep–wake cycle and psychomotor behaviour.

Indicative causes

Common

- 166. Delirium
 - 119. Cerebrovascular disease or cerebral injury
 - 206. Electrolyte disturbances (e.g. hyponatraemia)
 - 218. Epilepsy
 - 279. Head injury
 - Intercurrent illness
 - 189. Drug side effects (e.g. opioids, steroids, psychotropics, anaesthetics)
 - Metabolic disorder (e.g. 305. Hypoglycaemia, 7. Acidosis)
 - Organ failure (e.g. 105. Cardiac failure, 555. Renal failure, 356. Liver failure)
 - 190. Drug use (e.g. substance intoxication or withdrawal including alcohol, and illicit and synthetic drugs)
- 167. Dementia
 - 20. Alzheimer disease
 - 168. Dementia with Lewy bodies
 - 241. Fronto-temporal dementia
 - 672. Vascular dementia
 - Mixed dementia
- 172. Depression

Not so common, though not to miss

- 114. Cerebral haemorrhage
- 300. Hypertensive encephalopathy
- 426. Nutritional deficiencies
- 598. Space-occupying lesion
- Toxin exposure

Key considerations

- Duration of the delirium may persist beyond the duration of the causative illness

Common pitfalls

- Assuming intoxication before other causes have been excluded
- Attributing confusion to age without further investigation or consideration
- Missing delirium if the patient is hypoactive or apathetic
- Not recognising that delirium and dementia may coexist
- Premature use of medications before sensory orientation (e.g. reassurance, ensuring access to visual and hearing aids)

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may experience thoughts or perceptual phenomena that are specific to their spiritual and cultural beliefs, and therefore these may be culturally appropriate
- Aboriginal English, a creole or pidgin language, could be mistaken for confusion
- Delirium occurs more frequently among older patients in hospital and residents of aged-care facilities
- People with Down syndrome are at greater risk of Alzheimer disease

See also

- [Functional decline or impairment >](#)

27. Contraception

Overview

Contraception is the means for the intentional avoidance of becoming pregnant.

Effectiveness depends on the method used and adherence to recommended use.

Some forms of contraception are contraindicated due to comorbidities or risks.

Counselling should cover the patient's reason for seeking contraception; the advantages and disadvantages of the various methods, including side effects; and education on how and when the different forms of contraception are used. Counselling about contraception should include a discussion about sexually transmissible infections.

Breastfeeding alone is not a reliable form of contraception. However, the combined oral contraceptive pill, which contains estrogen, should be avoided during the first few months of lactation as it may jeopardise milk supply.

Types

- **Reversible**
 - Abstinence
 - Barrier—diaphragm, cervical cap, condom
 - Hormonal—oral, injectable, emergency contraception pill, levonorgestrel-releasing intrauterine contraceptive device (IUCD; e.g. Mirena), contraceptive implant (e.g. Implanon NXT)
 - Non-hormonal IUCD
 - Ovulation (Billings) or rhythm methods
- **Permanent**
 - Sterilisation—male or female

Key considerations

- Attitudes to contraception vary according to cultural or religious beliefs. Sexual activity is common before marriage, and many couples live in de facto arrangements.
- Most forms of contraception do not protect against sexually transmissible infections
- Some forms of 'contraception' are less reliable (e.g. breastfeeding, withdrawal, rhythm method, Billings method)

Consideration of specific groups

- Although pregnancy is family business in Aboriginal and/or Torres Strait Islander populations, the decision to use contraception most often falls upon the women
- History of forced sterilisation and/or coercion to accept implanted devices in Aboriginal and/or Torres Strait Islander populations may undermine trust in the health system; see [Historical and political determinants of health](#) for more information
- Teenagers may present for contraception without parental consent. An assessment should be made of their capacity to make an informed decision about being sexually active and about contraception, and their susceptibility to coercive sexual activity.
- Women in the perimenopausal period may still require contraception

See also

- [Consent >](#)
- [Unplanned pregnancy >](#)

28. Cough

Overview

Although cough is most frequently related to the upper or lower respiratory tract, it can also be a medication side effect or due to disease in the gastrointestinal tract. Differential diagnoses depend on whether there is sputum production, the nature of the sputum and whether there is haemoptysis.

Particular attention needs to be paid when children are presenting with cough because of the risk of bronchiectasis and asthma.

Indicative causes

Common

- 51. Asthma
- 189. Drug side effects (e.g. angiotensin converting enzyme inhibitors)
- 246. Gastro-oesophageal reflux disease
- Habitual or psychogenic (e.g. 596. Somatic symptom disorder)
- 511. Post-nasal drip
- 358. Lower respiratory tract infection
- 656. Upper respiratory tract infection

Not so common, though not to miss

- 50. Aspiration pneumonia
- 95. Bronchiectasis
- 160. Cystic fibrosis
- 238. Foreign body aspiration or 239. Foreign body trauma
- Haemoptysis from 537. Pulmonary hypertension, 138. Coagulopathy, 649. Trauma, 238. Foreign body aspiration, 239. Foreign body trauma, 44. Arteriovenous malformations
- 359. Lung abscess
- 360. Lung malignancy
- 490. Pertussis
- 500. Pleural effusion
- Protracted bacterial 97. Bronchitis
- 536. Pulmonary embolism
- 655. Tuberculosis

Key considerations

- Persistent cough requires investigation
- Sputum production in smokers may worsen for some time after quitting
- Use caution with cough suppressant medication

Consideration of specific groups

- Aboriginal, Torres Strait Islander children are at increased risk of bronchiectasis that features chronic cough
- People with immunosuppression
- Specific consulting skills and/or transfer to another healthcare facility are required for Aboriginal and/or Torres Strait Islander infants, as outlined in [Aboriginal and Torres Strait Islander views of health](#)

See also

- [Chest discomfort and pain >](#)
- [Difficulty breathing—shortness of breath >](#)
- [Difficulty breathing—wheezing or noisy breathing >](#)

29. Cyanosed neonate or infant

Overview

Central cyanosis in an infant is always abnormal, and can have cardiac or respiratory causes. Acrocyanosis (cyanosis of the hands and feet) is normal among newborn babies in the first days of life.

Indicative causes

- 39. Apnoea of prematurity
- 98. BRUE (brief resolved unexplained event)
- 147. Congenital heart disease (e.g. cyanotic, persistent pulmonary hypertension of the newborn)
- 358. Lower respiratory tract infection
- 382. Meconium aspiration syndrome
- 583. Sepsis

Key considerations

- Breath-holding among infants and toddlers
- Cyanosis in an infant always requires explanation

Common pitfall

- Cyanosis may be missed in people with darker skin

30. Developmental abnormality

Overview

The spectrum of what is regarded as normal is wide, but children who are not attaining normal developmental milestones require assessment for underlying causes. Children may present in infancy with generalised hypotonia ('floppy' infant)—this is usually a marker of neurological and/or muscular disease. Assessment should include the domains of gross motor, fine motor, speech and language and social development.

Indicative causes

Common

- 57. Autism spectrum disorder (particularly affecting speech and social development)
- 260. Global developmental delay (often a formal diagnosis cannot be made)
- Vision or hearing impairment

Not so common, though not to miss

- 116. Cerebral palsy
- Chromosomal abnormalities (e.g. 187. Down syndrome)
- 230. Fetal alcohol spectrum disorder
- 410. Myopathy (e.g. 404. Muscular dystrophy)
- Neglect (physical or emotional)
- Neuromuscular disorders (e.g. 602. Spinal muscular atrophy)

Key considerations

- Hearing and vision should always be assessed, as impairments in these domains are common reversible causes of developmental delay
- Specialised paediatric and allied health input are necessary for assessment and early intervention

Consideration of specific groups

- Specific consulting skills and/or referrals to other organisations and specialised health practitioners are required for Aboriginal and/or Torres Strait Islander infants, as outlined in [Aboriginal and Torres Strait Islander views of health](#)

See also

- Behavioural problem in childhood >
- Failure to thrive >

31. Difficulty breathing—shortness of breath

Overview

Breathing difficulty can be the prime manifestation of lung disease, heart disease, anaemia, neuromuscular disorders, trauma, sepsis, abdominal disease, deconditioning or anxiety. Shortness of breath may not necessarily correlate with pH, oxygen or carbon dioxide levels, or respiratory function.

Indicative causes

Common

- 31. Anxiety
- 51. Asthma
- 105. Cardiac failure
- 559. Restrictive and obstructive lung diseases
- 431. Occupational lung disease
- 358. Lower respiratory tract infection

Not so common, though not to miss

- 48. Aspirated foreign body
- 649. Chest trauma
- 126. Chest wall weakness
- 360. Lung malignancy (cancer)
- 189. Drug side effects (e.g. beta blocker)
- 455. Ovarian hyperstimulation syndrome among women undergoing assisted reproductive technology treatment
- 500. Pleural effusion
- 504. Pneumothorax
- 525. Primary pulmonary hypertension
- 536. Pulmonary embolism
- 655. Tuberculosis

Key considerations

Common pitfalls

- Failure to explore beyond the respiratory system
- Not looking at the context (environmental or occupational)
- Not recognising the functional consequences

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may describe shortness of breath with the phrase 'short wind'
- Babies with respiratory distress syndrome
- People exposed to asbestos
- People who smoke
- People with cystic fibrosis
- Specific occupations (e.g. stonemasons, saw millers, coalminers)

See also

- [Abnormal heart sounds and murmurs >](#)

32. Difficulty breathing—wheezing or noisy breathing

Overview

Wheezing is a whistling sound produced by vibration of walls of an airway that is nearly closed. It can originate from upper airways down to intrathoracic small airways. Stridor, a harsher sound, indicates extreme difficulty with breathing, or impending obstruction. Asthma is the most common cause of airflow limitation. Other noisy breathing can arise from the nasal passages.

Indicative causes

Common

- Extrathoracic upper airway obstruction
 - 430. Obstructive sleep apnoea
 - 511. Post-nasal drip or inflammation
- Intrathoracic upper airway obstruction
 - 645. Tracheobronchitis
- Lower respiratory tract disorders
 - 49. Aspiration
 - 51. Asthma
 - 96. Bronchiolitis
 - 133. Chronic obstructive lung disease
 - 538. Pulmonary oedema

Not so common, though not to miss

- 19. Allergic reaction
- 189. Drug side effects (e.g. beta blocker, amiodarone)
- Extrathoracic upper airway obstruction
 - 24. Anaphylaxis
 - 217. Epiglottitis
 - 264. Goitre
 - 346. Laryngeal oedema
- Intrathoracic upper airway obstruction
 - 238. Foreign body aspiration
 - 360. Lung malignancy (e.g. neoplasm)
- Lower respiratory tract disorders
 - 95. Bronchiectasis
 - 160. Cystic fibrosis
- 536. Pulmonary embolism

Key considerations

- Consider reflux oesophagitis
- Distinguish respiratory and cardiac causes of symptoms
- High fever and a soft inspiratory stridor in a child who sits leaning forward is highly suggestive of epiglottitis at risk of obstruction
- The triad of wheezing, chronic dyspnoea and cough is highly suggestive of asthma
- Untreated persistent respiratory infections can lead to complications such as bronchiectasis

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may describe shortness of breath with the phrase 'short wind'

See also

- [Cough >](#)
- [Difficulty speaking and hoarseness >](#)
- [Foreign body—orifice >](#)
- [Snoring >](#)

33. Difficulty sleeping

Overview

Difficulty sleeping affects about one-third of the population at some time of life and may be persistent in 10%. Difficulty in initiating or maintaining sleep, resulting in inadequate quantity or quality of sleep, can cause daytime sleepiness and impaired function. There is a wide variation in how much sleep each individual needs. As people age, their sleep patterns are more easily disturbed.

Indicative causes

Common

- 31. Anxiety
- 135. Circadian sleep disorder
- 172. Depression
- Environmental factors
- 246. Gastro-oesophageal reflux disease
- Normal variation
- Pain
- Poor sleep hygiene
- 514. Post-traumatic stress disorder
- 519. Pregnancy
- 593. Sleep apnoea
- 189. Drug side effects (e.g. alcohol, caffeine, or other drug/substance use or withdrawal)

Not so common, though not to miss

- Endocrine and metabolic disorders (e.g. poorly controlled 180. Diabetes mellitus, 301. Hypertension, 302. Hyperthyroidism)
- 375. Mania and hypomania
- 388. Menopause
- 421. Nocturnal myoclonus
- 558. Restless legs syndrome
- Some conditions cause hypersomnia (e.g. 413. Narcolepsy)

Key considerations

- Consider giving advice on good sleep hygiene practice

Common pitfalls

- Assuming that less than 7 hours of sleep per night is abnormal
- Lack of awareness of the adverse consequences of long-term use of hypnotics and benzodiazepines
- Missing the side effect of insomnia associated with corticosteroids, thyroxine, stimulants, antidepressants, analgesics, antipsychotics, aripiprazole
- Not identifying the impact of a comorbid condition (e.g. chronic pain, nocturia, itch, tinnitus)
- Not recognising contribution of alcohol, nicotine, caffeine, cannabis or other recreational drugs

Consideration of specific groups

- Shift workers
- Travellers experiencing jet lag

See also

- [Anxiety >](#)
- [Mood dysfunction >](#)

34. Difficulty speaking and hoarseness

Overview

Hoarseness (dysphonia) represents a change in the quality of the voice. Dysphasia is a problem with language. Dysarthria is a problem with speaking which results in slurring of words. An important first step is to differentiate which is present, as this will help determine the cause.

Indicative causes

Common

- **Dysarthria**
 - Localised mouth or throat problems
 - Neurological (e.g. 610. Stroke, 469. Parkinson disease)
- **Dysphasia**
 - Neurological (e.g. 610. Stroke)
- **Dysphonia**
 - 656. Infection
 - Irritants (e.g. 511. Post-nasal drip, smoking, 246. Gastro-oesophageal reflux disease)
 - 189. Drug side effects (e.g. steroid inhalers, danazol)
 - Overuse (acute or chronic)

Not so common, though not to miss

- 57. Autism spectrum disorder among children
- Degenerative neurological conditions (e.g. 407. Myasthenia gravis, 398. Motor neurone disease)
- 173. Depression with mutism
- 306. Hypothyroidism
- 345. Laryngeal cancer
- 532. Pseudobulbar palsy
- 548. Recurrent laryngeal nerve palsy

Key considerations

- Any patient with unexplained persistent hoarseness (> 2 weeks) requires clinical assessment and direct visualisation of the vocal cords
- Recurrent laryngeal nerve palsy may be a consequence of head and neck surgery, or an underlying problem in the thorax (e.g. Pancoast tumour or aortic arch aneurysm)

See also

- [Difficulty swallowing >](#)
- [Hearing problem >](#)

35. Difficulty swallowing

Overview

Difficulty swallowing can be caused by oral or pharyngeal disease; oesophageal obstruction or dysfunction; neurological problems (central or peripheral); or psychological disorders.

Indicative causes

Common

- 31. Anxiety
- 167. Dementia
- 246. Gastro-oesophageal reflux disease
- Oral or pharyngeal
 - 399. Mouth ulcers
 - 345. Laryngeal cancer or 432. Oesophageal cancer
 - 492. Pharyngeal pouch
 - 493. Pharyngitis
 - 639. Tonsillitis
- 610. Stroke
- Thyroid mass (e.g. 264. Goitre)

Not so common, though not to miss

- 100. Bulbar or pseudobulbar palsy
- 103. Candidiasis (e.g. secondary to poor steroid inhaler technique)
- 261. Globus pharyngeus
- Localised cranial nerve palsy
- Oesophageal
 - 6. Achalasia
 - 73. Benign oesophageal stricture
 - 238. Foreign body aspiration or 239. Foreign body trauma
- 502. Plummer–Vinson syndrome (dysphagia associated with 335. Iron deficiency anaemia)
- 580. Scleroderma
- Swallowing or inhaling corrosive liquids
- Weight-loss surgery or band

Key considerations

- Malnutrition can occur without weight loss

Common pitfalls

- Failure to think beyond one system
- Not examining for supraclavicular lymph nodes—if present, these always require urgent investigation to exclude malignancy

See also

- [Choking >](#)
- [Difficulty speaking and hoarseness >](#)
- [Dry mouth >](#)
- [Mouth or throat problem >](#)
- [Neck lump >](#)

36. Dizziness, light-headedness and vertigo

Overview

Dizziness is a non-specific term for the feeling of light-headedness or faintness; unsteadiness or a loss of balance; or a feeling of spinning. These sensations may be triggered or worsened by walking, standing up or moving the head, with an associated increase in risk of falls.

Light-headedness can signify metabolic (e.g. hypoglycaemia) or circulatory (e.g. low blood pressure) problems.

Vertigo is the feeling that the person or their surroundings are moving when they are still. It may be associated with nausea, poor balance and difficulty walking.

Patients may find it difficult to differentiate between symptoms of disequilibrium and light-headedness, but such differentiation can be helpful diagnostically. Associated clinical manifestations of nausea, nystagmus, hearing loss, unstable gait or a positive Dix–Hallpike manoeuvre can assist diagnosis.

Indicative causes

Dizziness

Common

- 17. Alcohol use or 190. Drug use
- 165. Dehydration
- 189. Drug side effects (e.g. diazepam, antihypertensives, antidepressants)
- Poor balance from 162. Deconditioning, muscle weakness or joint disorders
- 517. Postural hypotension
- 679. Vasovagal or vasodepressor syncope

Not so common, though not to miss

- 41. Arrhythmias (e.g. 54. Atrial fibrillation, 55. Atrial flutter, 281. Heart block, 682. Ventricular tachyarrhythmias)
- 303. Hyperventilation
- 305. Hypoglycaemia
- Psychogenic causes (e.g. 31. Anxiety, 172. Depression, 597. Somatisation)
- Subacute blood loss

Vertigo

Common

- 74. Benign paroxysmal positional vertigo
- Inner ear problems (e.g. 344. Labyrinthitis, 385. Ménière disease)
- 397. Motion sickness

Not so common, though not to miss

- 9. Acoustic neuroma
- 113. Cerebellar disease
- 119. Cerebrovascular disease or cerebral injury, or 647. Transient ischaemic attack (e.g. 348. Lateral medullary syndrome with Horner syndrome)
- 392. Vestibular migraine

Key considerations

Common pitfalls

- Assuming intoxication before other causes have been excluded
- Detecting postural hypotension and assuming this is the sole cause
- Missing hypoglycaemia
- Not recognising the functional and safety consequences of vertigo and dizziness at work, home or for driving

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may consider the experience of light-headedness as a manifestation of spiritual and cultural beliefs, and therefore this may be culturally appropriate
- Older people are at increased risk of central causes of vertigo (e.g. stroke), heat stroke and dehydration

See also

- [Faintness and collapse >](#)

37. Dry mouth

Overview

Persistent dry mouth may result from a localised or systemic condition. It may be diagnosed and managed by medical and/or dental practitioners. It can manifest with halitosis.

Indicative causes

Common

- Autoimmune (e.g. 590. Sjögren syndrome)
- 165. Dehydration
- 189. Drug side effects (particularly medications with anticholinergic actions)
- Mouth breathing

Not so common, though not to miss

- 31. Anxiety, 689. Stress, 190. Drug use or 17. Alcohol use
- Oral 586. sexually transmissible infection or other infection
- Head and neck radiotherapy

Key considerations

- Dry mouth increases the risk of dental caries

Common pitfalls

- Not considering autoimmune disorders
- Not considering the impact on nutrition

See also

- [Bad breath >](#)
- [Difficulty swallowing >](#)
- [Mouth or throat problem >](#)

38. Dying patient

Overview

Dying patient refers to a patient nearing the end of their life, which could be hours, days or weeks away. Management should include the provision of physical, psychological, social and spiritual care for patients and their loved ones.

Management of dying is a complex process, and the needs of the patient and family may change over time. It includes respecting patient autonomy and desires regarding their care plans and the information they want to receive. Such plans include their advance care directives, prior and current wishes, and palliation of symptoms. The plan should ensure adequate control of pain, relief of anxiety and depression, respect for patient autonomy, and maintenance of dignity and privacy.

Key considerations

- Euthanasia laws vary by state
- For patients who are currently incompetent, insensible or unable to express their wishes, it is important to determine the status of an advance care directive or other information regarding their wishes
- Norms and expectations vary between cultures. Specific cultural advice may be needed.
- Patients and their families vary in their desired degree of autonomy in decision making and the degree to which their cultural and spiritual practices should be considered. This includes their wishes regarding location and events leading up to and after their death.
- Symptom control extends beyond management of pain and may require expert advice (e.g. from palliative care services)
- The process of a patient dying also affects carers and health professionals, so attention to self-care and support from specialist palliative care teams should be considered

Common pitfalls

- Futile prolongation of life
- Isolating the patient from family and loved ones
- Not anticipating and managing side effects of treatments (e.g. constipation from opioids)
- Not documenting the patient's advance care directive
- Respecting the family's wishes instead of the patient's wishes

See also

- [Advance care directive >](#)
- [Coroner and cause of death certification >](#)
- [End-of-life issues, euthanasia and assisted suicide >](#)
- [Organ and tissue donation and transplantation >](#)
- [Recognising limitations and calling for help >](#)

39. Ear problem

Overview

Ear problems (pain, discharge, malformations) are among the most common reasons for patient presentation to general practices and emergency departments. Pain and/or discharge are the most frequent symptoms. Chronic problems can lead to hearing impairment with its associated impact on communication, social functioning and, among children, developmental delay.

Indicative causes

Common

- Infection
 - 112. Cellulitis
 - 451. Otitis externa
 - 452. Otitis media
- Obstruction
 - 198. Impacted earwax
- Referred pain
 - 309. Impacted wisdom teeth
 - 471. Parotitis
 - 493. Pharyngitis or 639. Tonsillitis
 - 626. Temporal arteritis
 - 627. Temporomandibular joint dysfunction
- 649. Trauma
 - 66. Barotrauma
 - 238. Foreign body aspiration or 239. Foreign body trauma
 - Injury

Not so common, though not to miss

- Congenital abnormalities
- 291. Herpes zoster
- 379. Mastoiditis (including with 130. Cholesteatoma)
- Tumour
 - 69. Basal cell carcinoma
 - 446. Osteoma
 - 606. Squamous cell carcinoma

Key considerations

- Chronic suppurative otitis media sometimes goes undiagnosed; however, treatment is required to prevent long-term consequences (e.g. hearing loss)
- Otitis externa ('tropical ear' or 'swimmer's ear') is common in northern Australia in summer

Consideration of specific groups

- Chronic suppurative otitis media is endemic among Aboriginal and/or Torres Strait Islander children living in remote communities, and is also present in other communities at a higher incidence than in non-Indigenous children

See also

- [Foreign body—orifice >](#)
- [Hearing problem >](#)
- [Tinnitus >](#)

40. Eye—red or painful

Overview

Red eye can be the first indication of a serious sight-threatening condition. The important initial task is to determine if a condition is present that requires urgent specialised management.

Indicative causes

Common

- 82. Blepharitis
- 125. Chalazion
- 149. Conjunctivitis (infectious, allergic or irritative)
- 192. Dry eye syndrome
- 213. Entropion
- 613. Subconjunctival haemorrhage (spontaneous, traumatic, or due to systemic illness)
- 649. Trauma, including corneal abrasion and penetrating injuries, chemical splashes, or 238. Foreign body aspiration or 239. Foreign body trauma

Not so common, though not to miss

- 259. Glaucoma
- 289. Herpes simplex
- 334. Iritis (infection, inflammation, infiltration)
- 342. Keratitis
- 579. Scleritis, episcleritis and uveitis (e.g. 59. Autoimmune and connective tissue diseases, 678. Vasculitis, 318. Infection)

Key considerations

- Foreign body removal requires appropriate equipment and expertise
- Further specialised review is needed if there is:
 - abnormal pupillary size or reactivity
 - change in visual acuity
 - penetrating injury
 - photophobia

Common pitfall

- Eye injuries can be missed when patients have altered consciousness

Consideration of specific groups

- Home renovators and workers (or bystanders) who do not use eye protection are at risk of foreign body from metal-on-metal work, penetrating injury and flash burns
- Trachoma is prevalent in Aboriginal and/or Torres Strait Islander communities

See also

- [Altered vision >](#)
- [Eye—swollen or discharging >](#)

41. Eye—swollen or discharging

Overview

A swollen or discharging eye indicates a periorbital, conjunctival, lacrimal duct or eyelid problem. The eye can appear swollen when there is exophthalmos due to increased retro-orbital tissue. The approach will depend on whether the vision is affected, whether the problem involves one or both eyes and whether other systems are affected.

Indicative causes

Common

- 19. Allergic reaction or 278. Hayfever
- 83. Blocked lacrimal duct
- 149. Conjunctivitis (infectious, allergic or irritative)
- 238. Foreign body aspiration, 239. Foreign body trauma or 649. Trauma
- 611. Stye or 383. Meibomian cyst

Not so common, though not to miss

- 111. Cavernous sinus thrombosis
- Generalised oedematous states (e.g. 416. Nephrotic syndrome)
- 267. Graves disease with exophthalmos
- 440. Orbital fracture
- 439. Orbital cellulitis or 483. Periorbital cellulitis
- 618. Superior vena cava obstruction

Key considerations

- Associated red eye raises other, potentially serious, diagnostic possibilities
- Change in visual acuity requires further specialised review
- Orbital or periorbital cellulitis has potentially serious complications and requires urgent treatment

Consideration of specific groups

- Trachoma is prevalent in Aboriginal and/or Torres Strait Islander communities

See also

- [Altered vision >](#)
- [Eye—red or Painful >](#)

42. Failure to thrive

Overview

Failure to thrive is a common reason for presentation in infancy and early childhood, and is best identified by a child's weight, length or height dropping from the appropriate expected trajectory on a relevant growth chart.

It is most commonly associated with inadequate nutrition but can also be a marker of underlying disease.

Abnormal head growth, short stature or tall stature raise other diagnostic possibilities.

Indicative causes

Common

- Inadequate oral intake due to non-organic causes

Not so common, though not to miss

- Genetic syndromes
- 312. Inborn errors of metabolism
- Increased metabolic requirements (e.g. due to 147. Congenital heart disease, renal losses, 302. Hyperthyroidism, 160. Cystic fibrosis, chronic infections, inflammatory disorders)
- Malabsorption (e.g. due to 154. Cow's milk protein intolerance, 465. Pancreatic insufficiency, 139. Coeliac disease)
- Neglect

Key considerations

- Assessment requires a thorough dietary history; exploration of breastfeeding problems is essential in younger infants
- Consider maternal nutrition and food security at home
- Expert input is needed if failure to thrive persists in spite of adequate nutrition
- Look at the trajectory of all three growth parameters (length, head circumference and weight) and seek expert advice when failure to thrive is associated with microcephaly and/or stunting

Consideration of specific groups

- Poor nutrition and/or food insecurity is more common among people with financial difficulties or vulnerable social circumstances
- Prolonged exclusive breastfeeding of children may result in nutrient deficiencies (e.g. iron)

See also

- [Behavioural problem in childhood >](#)
- [Breastfeeding problem >](#)
- [Developmental abnormality >](#)
- [Feeding problem in a child >](#)

43. Faintness and collapse

Overview

Faintness and collapse usually occur because of global cerebral hypoperfusion. When it causes transient, self-limiting loss of consciousness (syncope) it may lead to falling. Faintness and collapse are common, increase with age and cause significant morbidity among older people.

Indicative causes

Common

- 41. Arrhythmias (e.g. 54. Atrial fibrillation, 55. Atrial flutter, 281. Heart block, 682. Ventricular tachyarrhythmias)
- 218. Epilepsy
- 303. Hyperventilation
- 679. Neurally mediated reflex syncopal syndromes (e.g. carotid sinus syncope due to cough, micturition, exercise)
- Orthostatic
 - 517. Postural hypotension (e.g. due to 190. Drug use, volume depletion, 284. Heat stroke)
 - 60. Autonomic neuropathy (e.g. Idiopathic, 469. Parkinson disease, 180. Diabetes mellitus)
- 679. Vasovagal or vasodepressor syncope (simple faint)

Not so common, though not to miss

- 34. Aortic dissection
- Cardiac
 - 339. Ischaemic heart disease
 - 429. Obstructive cardiomyopathy
 - 479. Pericardial tamponade
 - 537. Pulmonary hypertension
 - 36. Aortic stenosis
- 305. Hypoglycaemia
- 536. Pulmonary embolism
- 610. Stroke

Key considerations

- Assess volume status, including standing blood pressure
- Differentiate syncope from seizure, but note that seizure can be precipitated by syncope
- Exercise-induced syncope suggests a cardiac cause

Common pitfalls

- Not conducting a thorough examination of limbs, abdomen and pulses from aorta to periphery including listening for bruits
- Not obtaining an observer history
- Prematurely attributing transient loss of consciousness to a transient ischaemic attack

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may consider the experience of faintness as a manifestation of spiritual and cultural beliefs, and therefore this may be culturally appropriate
- Older people
- People on antihypertensive medication
- Pregnant women

See also

- [Abnormal heart sounds and murmurs >](#)
- [Altered level of consciousness >](#)
- [Dizziness, light-headedness and vertigo >](#)
- [Palpitations >](#)
- [Seizures and convulsions >](#)

44. Falls

Overview

Falls are an important cause of morbidity among older people and often have a multifactorial aetiology. They can be caused by trauma, trips, problems with balance and/or loss of consciousness. Patients can often recall a trip, sometimes recall problems with balance, but cannot recall loss of consciousness.

Indicative causes

Common

- Loss of consciousness
 - Acute illness
 - 517. Postural hypotension
 - 679. Vasovagal or vasodepressor syncope
- Poor balance
 - 190. Drug use and 17. Alcohol use
 - Vestibular problems (e.g. 385. Ménière disease)
 - Cerebellar problems
- Muscle weakness
- Trips
 - Environmental hazards
 - Inappropriate footwear
 - Inattention
 - Visual impairment

Not so common, though not to miss

- Spontaneous fracture of neck of femur

Key considerations

- A collateral history is usually very helpful
- The single most important risk factor is history of a prior fall

Common pitfall

- Not considering multifactorial causes after a single cause has been identified

Consideration of specific groups

- Older people

See also

- [Faintness and collapse >](#)
- [Functional decline or impairment >](#)
- [Gait disturbance >](#)

45. Fatigue, lethargy and malaise

Overview

Patients will commonly present with fatigue, which often has no easily identifiable underlying cause, but can also be the marker of serious illness. Exploration of associated symptoms, from many different systems, can help in diagnosis. Patients may describe symptoms such as weariness, tiredness, lacking energy, listlessness, exhaustion, weakness, or feeling 'run down'. Patients sometimes conflate fatigue with sleepiness or sleeplessness.

Indicative causes

Common

- 22. Anaemia
- 31. Anxiety
- 75. Bereavement and grief
- 282. Heart failure (cardiac disease)
- 132. Chronic fatigue syndrome
- 172. Depression
- 235. Fibromyalgia
- 306. Hypothyroidism
- 318. Infection (bacterial, viral, fungal)
- 189. Drug side effects
- Physiological changes of pregnancy
- Respiratory disease
- Sleep disorder or 593. Sleep apnoea
- 190. Drug use

Not so common, though not to miss

- Immune disorder (e.g. 569. Rheumatoid arthritis)
- 370. Malignancy
- Metabolic disorder (e.g. 555. Renal failure, 355. Liver disease, 206. Electrolyte disturbances)
- Neurological conditions (e.g. 402. Multiple sclerosis, 398. Motor neurone disease, 407. Myasthenia gravis)

Key considerations

- The challenge is to identify underlying treatable illnesses

Common pitfalls

- Failing to identify associated systemic symptoms (e.g. weight loss, fever, appetite loss)
- Misattributing an incidental laboratory abnormality as the cause
- Not considering lifestyle factors

Consideration of specific groups

- Pregnant women

See also

- [Mood dysfunction >](#)

46. Febrile child

Overview

Fever is common among children, but can be the harbinger of serious illness.

Indicative causes

Common

- Acute 452. otitis media
- Systemic 684. Viral infections (e.g. enterovirus, Epstein–Barr virus)
- 663. Urinary tract infection
- 683. Viral gastroenteritis
- 685. Viral upper respiratory tract infection

Not so common, though not to miss

- 64. Bacteraemia
- 341. Kawasaki disease
- 386. Meningitis
- 447. Osteomyelitis or 584. Septic arthritis
- 503. Pneumonia
- 567. Rheumatic fever
- Vaccine-preventable diseases (e.g. 668. Varicella, 380. Measles)

Key considerations

- Expert input is often required for infants and always when younger than 3 months
- Immunisation history is always required
- Localising signs are often absent, especially among infants
- Prolonged fever suggests other possible diagnoses (e.g. atypical infections, systemic inflammatory disorders, malignancy)
- Published algorithms for investigation and treatment can be helpful
- Younger children have a higher risk of serious bacterial infections

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander children aged 5–15 years are at increased risk of acute rheumatic fever and otitis media

See also

- [Fever >](#)
- [Immunisations >](#)

47. Feeding problem in a child

Overview

Paediatric feeding problems refer to inadequate or disordered intake of food by a child, or the parent's or carer's perception of this.

Most children who present with feeding problems are healthy, with the problem arising from a misunderstanding of the child's nutritional needs. However, a minority will have a serious underlying disease.

The history taken must be age-appropriate, with specific questioning to ascertain the nature of the feeding abnormality and to discern the cause; for instance, whether incoordinate swallowing, fatigability or behavioural issues are present. Most issues will resolve with coaching and support, but a detailed examination and appropriate investigations should inform more specific management focused on the underlying diagnosis.

Indicative causes

Common

- Anatomical variation in the infant's mouth
- 70. Behavioural problems
- Decreased appetite associated with illness
- 237. Food intolerance
- 246. Gastro-oesophageal reflux disease
- Maternal and infant breastfeeding problems (e.g. 333. Inverted nipples, poor suck or coordination)
- Nasal obstruction due to minor respiratory infection
- Pain
- Parental misunderstanding of infant/child requirements
- Swallowing disorders

Not so common, though not to miss

- Avoidant/restrictive food intake disorder
- 147. Congenital heart disease (e.g. undiagnosed ventricular septal defect, 105. Cardiac failure)
- Child abuse and neglect
- 172. Depression and other mental health issues
- Immune-based 237. Food intolerance
- Neuromuscular abnormality leading to weakness, incoordinate swallowing or 49. Aspiration (e.g. 116. Cerebral palsy, 410. Myopathy)

- Oesophageal abnormality (congenital or post-surgery)
- Oropharyngeal abnormality (e.g. 461. Overt or submucous cleft palate)
- Respiratory disease (e.g. neonatal chronic lung disease)
- Underlying chronic illness (e.g. idiopathic arthritis)

Key considerations

- The child's age is critical, as underlying causes are stage-specific

Common pitfalls

- Not considering that feeding problems may be indicative of significant underlying disease
- Not recognising specific needs of infants during weaning
- Not recognising that infants' and toddlers' attitudes towards food and meals may be a mechanism to assert independence

Consideration of specific groups

- Children with neuromuscular conditions are at increased risk of aspiration
- Food safety and food security can vary in different communities
- Neonates establishing breastfeeding

See also

- [Behavioural problem in childhood >](#)
- [Failure to thrive >](#)
- [Involuntary weight loss >](#)
- [Voluntary weight loss >](#)

48. Fever

Overview

The cause of a fever is usually informed by other associated symptoms or recent events (e.g. contact with another infected person, travel or recent surgery). However, fever of unknown origin defines a febrile illness of 3 weeks or more without an established diagnosis despite appropriate investigation. Some instances resolve spontaneously, but common and serious underlying causes should be explored.

Indicative causes

Common

- 59. Autoimmune and connective tissue diseases (e.g. systemic lupus erythematosus, 569. Rheumatoid arthritis)
- 318. Infection (bacterial, viral, fungal) or 285. Helminthic infection (parasitic)
- 189. Drug side effects (e.g. anticonvulsants)
- Neoplastic (especially 364. Lymphoma)
- Postoperative
 - 5. Abscess within the operative site, 512. Post-operative infection
 - 358. Lower respiratory tract infection (chest infection)
 - 164. Deep vein thrombosis
 - 331. Intravenous cannula infection
 - 536. Pulmonary embolism
 - 663. Urinary tract infection, especially if the patient has an indwelling urinary catheter
 - 691. Wound infection

Not so common, though not to miss

- 21. Amyloidosis
- 226. Familial Mediterranean fever
- 315. Opportunistic or recurrent infection among people with immunosuppression
- 447. Osteomyelitis
- 567. Rheumatic fever
- 573. Sarcoidosis
- 612. Subacute bacterial endocarditis
- Tropical illnesses (e.g. 368. Malaria)
- 655. Tuberculosis

Key considerations

- A recurrent infection may occur from misdiagnosis, inadequate initial treatment or reinfection
- Neonates and older people may not have fevers associated with severe infections

Common pitfall

- Not considering a serious non-infective cause

Consideration of specific groups

- People who use intravenous drugs
- Returned travellers

See also

- [Departing and returning travellers >](#)
- [Febrile child >](#)
- [Sweating >](#)

49. Foreign body—orifice

Overview

Retention of a foreign body in an orifice may follow intentional or accidental insertion.

Indicative causes

Common

- Ears and nose
 - Cleaning implement (e.g. cotton buds)
 - Small toy or component
- Genital tract
 - Retained tampon
- Oesophagus and stomach
 - Button battery
 - Toy
- Oropharynx
 - Denture
 - Food (e.g. fish or chicken bones)

Not so common, though not to miss

- Concealment of drugs
- Objects used for sexual gratification (rectum or genital tract)
- Self-harm associated with 488. Personality disorder
- Surgical pack (e.g. following office gynaecological procedure)

Key considerations

- Ingested button batteries require urgent retrieval
- The nature of the foreign body should be determined promptly

See also

- Cough >
- Difficulty breathing—shortness of breath >
- Difficulty breathing—wheezing or noisy breathing >
- Ear problem >
- Nose problem >
- Vaginal discharge >

50. Fracture or dislocation

Overview

Fractures or dislocations are common at all ages and may be associated with significant morbidity. Fractures vary from simple 'greenstick' fractures among children to compound comminuted fractures in severe trauma, and may involve articular surfaces and be associated with dislocations.

Indicative causes

Common

- 449. Osteoporosis
- 649. Trauma

Not so common, though not to miss

- Genetic disorders (e.g. 445. Osteogenesis imperfecta)
- 473. Pathological fractures from primary or secondary cancer (370. Malignancy)
- 423. Non-accidental injury or physical abuse

Key considerations

- An episode of trauma can affect more than one bone, so look for other fractures or dislocations
- Dislocation of the radial head (pulled elbow) is common among young children
- Managing risk factors for osteoporosis
- Neurovascular complications may occur after reduction or relocation
- Non-orthopaedic complications of the injury include loss of neurovascular integrity, compartment syndrome, and internal organ injury
- Unexplained fracture in a child who is not yet mobilising independently raises the possibility of non-accidental injury

Consideration of specific groups

- Early surgical intervention and mobilisation may improve outcomes, particularly for older people

See also

- [Bone pain >](#)
- [Domestic violence, abuse and neglect >](#)
- [Joint problem >](#)
- [Muscle or soft tissue pain >](#)
- [Trauma—physical >](#)

51. Functional decline or impairment

Overview

Functional decline is the decrease in physical and/or cognitive functioning that threatens independence and engagement in activities of daily living. It is usually multifactorial in origin and is associated with age-related problems.

Failure to thrive and frailty among older adults are associated with poor nutrition, weight loss and physical inactivity. These can be compounded by comorbid physical and mental health conditions, and adverse social or financial circumstances.

Interventions usually require a combination of attention to medical problems, review of medications, provision of rehabilitation, optimising personal coping strategies, and social support.

Indicative causes

Functional decline can occur with any illness or as a medication side effect. However, common contributing causes are:

- 102. Cancer
- Cardiopulmonary disease (e.g. 282. Heart failure)
- 119. Cerebrovascular disease or cerebral injury
- Decompensation from hospitalisation
- 166. Delirium
- 167. Dementia
- 318. Infection (bacterial, viral, fungal)
- 206. Electrolyte disturbances (e.g. hyponatraemia)
- Mood disorders (e.g. 172. Depression, 31. Anxiety)
- Musculoskeletal problems
- Neurological conditions (e.g. 469. Parkinson disease)
- 426. Nutritional deficiencies
- Sensory impairment
- Thyroid disorders (e.g. 302. Hyperthyroidism, 306. Hypothyroidism)

Key considerations

- Assessment should be multimodal, multidisciplinary and culturally appropriate
- Regular exercise, balance training, cognitive stimulation and socialising can improve function

Common pitfalls

- Attributing problems solely to age
- Ignoring impaired function induced by immobility during hospitalisation
- Not exploring beyond one system or beyond the first problem identified
- Not looking at physical, environmental and social supports
- Overlooking the impact of polypharmacy

Consideration of specific groups

- People living in rural and remote areas may have limited access to appropriate services, which places a greater burden on families

See also

- [Advance care directive >](#)
- [Carer fatigue >](#)
- [Falls >](#)
- [Social aspects of health care >](#)

52. Gait disturbance

Overview

Abnormalities of gait may be painful or otherwise, and can result from disorders affecting the vascular, musculoskeletal or nervous systems.

Indicative causes

Common

- **Musculoskeletal**
 - Childhood hip disease (e.g. 337. Irritable hip or transient synovitis, 178. Developmental dysplasia of the hip, 489. Perthes disease, 594. Slipped upper femoral epiphysis)
 - 319. Inflammatory arthritides
 - 443. Osteoarthritis
 - Soft tissue disorders or injuries (e.g. 499. Plantar fasciitis, 605. Sprains, 608. strains)
 - 649. Trauma or fracture
 - Unequal leg length
- **Neurological**
 - Balance disturbance (e.g. cerebellar disorder, 385. Ménière disease)
 - 116. Cerebral palsy
 - 402. Multiple sclerosis
 - 469. Parkinson disease
 - 481. Peripheral neuropathy
 - 542. Radiculopathy
 - 600. Spinal canal stenosis
 - 610. Stroke
- **Vascular**
 - Intermittent claudication due to 485. Peripheral vascular disease
 - 681. Venous thrombosis

Not so common, though not to miss

- 117. Cerebral space-occupying lesion
- Chorea (e.g. 567. Rheumatic fever)
- 223. Factitious disorder (e.g. for compensation) or functional neurological disorder (e.g. 596. Somatic symptom disorder)
- 189. Drug side effects (e.g. dopamine antagonists, steroids)
- 410. Myopathy or 404. Muscular dystrophy

- 447. Osteomyelitis or 584. Septic arthritis
- 596. Somatic symptom disorder
- 601. Spinal cord lesion
- 614. Subcutaneous foreign body

Key considerations

- A thorough lower limb examination should include musculoskeletal, neurological and vascular systems
- Abnormalities may be missed because gait is not examined

Consideration of specific groups

- Chronic alcohol use can cause balance and peripheral nerve disturbance

See also

- [Back and neck pain >](#)
- [Bone pain >](#)
- [Falls >](#)
- [Involuntary movements >](#)
- [Joint problem >](#)
- [Muscle or soft tissue pain >](#)

53. Genital problem—female

Overview

Female genital symptoms include pain, lumps, itch, ulcers, blisters and discharge. They can have multiple causes, which vary according to age.

Indicative causes

Common

- 68. Bartholin cyst
- 318. Infection (bacterial, viral, fungal)
 - Bacterial vaginosis
 - 103. Candidiasis
 - 254. Genital warts
 - 289. Herpes simplex
 - Other 586. sexually transmissible infections, particularly 127. Chlamydia, 265. Gonorrhoea or 622. Syphilis
- 412. Nappy rash among infants
- 690. Vulval dermatoses

Not so common, though not to miss

- Autoimmune conditions that affect the skin can also affect the vulva
- 186. Donovanosis in tropical northern Australia
- Female labial adhesions among infants
- 228. Female genital mutilation
- 321. Inguinal hernia
- 353. Lichen sclerosus
- 5. Abscess (vulval)
- 689. Vulval and vaginal cancer

Key considerations

- Consider diabetes mellitus among women with recurrent candidiasis
- Consider partner testing and contact tracing for sexually transmissible infections
- Presentation can be delayed due to associated discomfort, fear and embarrassment

Common pitfalls

- Failure to appreciate the impact of symptoms
- If the patient is pregnant, not considering implications for vaginal birth
- Inappropriate management of a Bartholin cyst

Consideration of specific groups

- Migrant groups from countries where female genital mutilation is practised
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

See also

- [Skin rash and itch >](#)
- [Urinary problem >](#)
- [Vaginal bleeding >](#)
- [Vaginal discharge >](#)

54. Genital problem—male

Overview

Male genital symptoms can include groin or scrotal pain, itch or swelling. Diagnosis may be delayed due to patient embarrassment or because the groin and scrotum are not examined due to doctor reticence.

Indicative causes

Common

- Infection
 - 103. Candidiasis
 - 254. Genital warts
 - 289. Herpes simplex
 - Other 586. Sexually transmissible infections, particularly 127. Chlamydia, 265. Gonorrhoea or 622. Syphilis
 - 242. Fungal infection (tinea cruris)
- 321. Inguinal hernia
- 362. Lymphadenopathy
- 412. Nappy rash among infants
- Penile problems (e.g. 476. Phimosis)
- Scrotal
 - 216. Epididymitis
 - 297. Hydrocoele
 - 633. Testicular torsion
 - Undescended testis
 - 669. Varicocoele
- 649. Trauma

Not so common, though not to miss

- 186. Donovanosis in tropical northern Australia
- 291. Herpes zoster
- 403. Mumps orchitis
- Referred pain
- 632. Testicular cancer

Key considerations

- Epididymitis is commonly associated with urinary stasis among older men, and sexually transmissible infection among younger men
- If lymphadenopathy is present, consider if it is a systemic or local problem
- Testicular torsion requires urgent management

Consideration of specific groups

- Young men with testicular cancer

See also

- [Skin rash and itch >](#)
- [Urinary problem >](#)

55. Hair disorders

Overview

Loss of hair and excess hair are common and may have serious effects on self-esteem. Changes in hair quantity or distribution may reflect underlying systemic disease.

Indicative causes

Common

- **Excess hair (hirsutism)**
 - Androgenic endocrine disorders (e.g. 508. Polyendocrine metabolic ovarian syndrome [formerly referred to as polycystic ovary syndrome])
 - Familial
 - Idiopathic
- **Hair loss or absence (alopecia)**
 - Acute illness or 609. Stress
 - 59. Autoimmune and connective tissue diseases
 - 242. Fungal infection
 - 306. Hypothyroidism
 - 369. Male-pattern baldness and 229. Female-pattern baldness
 - 189. Drug side effects (e.g. chemotherapy)
 - 519. Pregnancy and postpartum
 - 373. Malnutrition

Not so common, though not to miss

- 521. Premature puberty
- 650. Trichotillomania

Key considerations

- Androgen and thyroid hormone profiles may be indicated
- It is important to establish whether there is a treatable endocrine disorder
- Look for signs of virilisation

Consideration of specific groups

- Hair may carry specific cultural significance and importance to many Aboriginal and/or Torres Strait Islander people, including how hair is disposed of or touched

See also

- [Skin rash and itch >](#)

56. Head injury

Overview

Head injuries can be mild or superficial, but can also result in skull or facial fractures and traumatic brain injuries.

Concussion is a brain injury resulting in temporary loss of consciousness, disorientation or confusion. Its impacts on function after head trauma may be mild, but can be severe and result in permanent brain damage.

Evaluation of head injury should focus on the cause and immediate effects, which may inform prognosis and strategies for prevention of recurrence.

Indicative causes

Common

- 649. Trauma from falls, motor vehicle accidents, sports- or work-related incidents, physical assaults

Not so common, though not to miss

- Delayed intracranial bleed
- 423. Non-accidental injury among infants (e.g. 587. Shaken baby syndrome)

Key considerations

- Assess mental state and cranial nerves
- Brain trauma may take some time to manifest, and is not always related to the severity of the initial head injury
- Consider short- and long-term cognitive and functional consequences
- Provide advice on prevention, as repeated head trauma has cumulative effects on brain function

Common pitfalls

- Assuming intoxication before other causes have been excluded
- Missing a cerebrospinal fluid leak or bleeding from the ear, which would suggest base of skull fracture
- Missing an associated cervical spine injury
- Not assessing for facial fractures
- Not obtaining a collateral history

Consideration of specific groups

- People taking anticoagulants are at increased risk of intracranial bleeding after trauma

See also

- [Eye—red or painful >](#)
- [Eye—swollen or discharging >](#)
- [Headache and facial pain >](#)
- [Skin wounds, injuries and ulcers >](#)

57. Headache and facial pain

Overview

Headaches are common, sometimes disabling, but mostly benign. Establishing the nature of the headache is important as this helps determine whether there is serious underlying disease and serves as a treatment guide.

Facial pain can be separate from, or can overlap with, headache and is often caused by localised disorders. Referred pain may also cause headache or facial pain.

Indicative causes

Common

- **Headache and/or facial pain**
 - 279. Head injury or concussion
 - 452. Otitis media or 451. Otitis externa
 - 607. Sinus infection or allergy
 - Fever and 318. Infection
- **Predominantly facial pain**
 - 99. Bruxism
 - 627. Temporomandibular joint dysfunction
 - 641. Toothache or 640. Tooth abscess
 - 652. Trigeminal neuralgia and facial neuralgia (including 291. Herpes zoster)
- **Predominantly headache**
 - 123. Cervical spondylosis
 - 301. High blood pressure
 - 190. Drug use, 189. Drug side effects or 191. Drug withdrawal
 - 392. Migraine
 - 630. Tension headache

Not so common, though not to miss

- 11. Acute glaucoma
- 137. Cluster headaches
- 157. Cranial arteritis
- 165. Dehydration or 617. Sunstroke
- Elevated cerebrospinal fluid pressure
 - 72. Benign intracranial hypertension
 - 296. Hydrocephalus
- Gases, vapours and fumes (e.g. carbon monoxide)
- 329. Intracranial lesions and bleeds

- 386. Meningitis
- 518. Preeclampsia

Key considerations

- Further investigation should be prompted by new onset or change in symptoms, fever, systemic or neurological symptoms, 'worst ever' headache, or head trauma

Common pitfalls

- 'Eye strain' is not a common cause of headache
- Medication withdrawal headache is often under-recognised

See also

- [Eye—red or painful >](#)
- [Head injury >](#)
- [Neck lump >](#)
- [Toothache >](#)

58. Hearing problem

Overview

Patients may present with hearing problems at any age, and these issues may have significant individual and societal impacts. Many causes of hearing loss are preventable. History, examination and investigations should be targeted at differentiating conductive and sensorineural hearing loss to guide further management.

Indicative causes

Common

- 144. Conductive deafness
 - Canal obstruction (e.g. 198. Earwax, 238. Foreign body aspiration, 239. Foreign body trauma)
 - 452. Otitis media (acute or chronic, with or without perforation)
 - 453. Otosclerosis
- Malfunctioning hearing aid
- Sensorineural deafness
 - Age-related
 - Congenital
 - 385. Ménière disease
 - Noise-induced
 - 649. Trauma-induced

Not so common, though not to miss

- 144. Conductive deafness
 - 130. Cholesteatoma
 - Tumour
- Sensorineural
 - 189. Drug side effects (e.g. aminoglycosides)
 - 402. Multiple sclerosis
 - 610. Stroke
 - Tumour

Key considerations

- Consider audiometry for all children who are suspected of having impaired hearing
- Consider hearing loss as a cause of:
 - behavioural, developmental and speech problems among children
 - confusion among older people
- Examination must include otoscopy (re-examine after wax removal) and bedside hearing tests
- If sensorineural loss is identified in a child, consider congenital infection or genetic abnormalities
- Investigations including audiometry are necessary to define extent of hearing loss, and to differentiate underlying disease

Common pitfalls

- Missed diagnosis among children or older people
- Missing opportunities for prevention (e.g. immunisation, antibiotic treatment, noise management)

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people have a high burden of chronic suppurative otitis media, which can cause acute and permanent hearing loss if untreated
- Children are at risk of conductive loss due to infection
- People with occupational noise exposure (e.g. building industry, manufacturing, music industry)

See also

- [Ear problem >](#)
- [Foreign body—orifice >](#)
- [Tinnitus >](#)

59. High blood pressure

Overview

High blood pressure (BP) requires interpretation in relation to other cardiovascular risk factors. It is asymptomatic among most patients, who frequently present with their own out-of-clinic BP recordings. The gold-standard method to assess BP, categorise patterns of hypertensive disorder and best predict cardiovascular disease outcome is 24-hour ambulatory BP monitoring. Home BP monitoring using a standardised device and unobserved automated office readings are recommended for monitoring responses to therapy. Correct choice of cuff size is essential for accurate measurement of BP among children and in adults with large arm circumferences.

Indicative causes

Common

- 221. Essential hypertension
- Hypertension (associated with one or more of the following)
 - 16. Alcohol excess
 - 180. Diabetes mellitus
 - 189. Drug side effects (e.g. non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids, antidepressants, methylphenidate, decongestants)
 - 427. Obesity
 - 593. Sleep apnoea

Not so common, though not to miss

- 33. Aortic coarctation
- 159. Cushing syndrome
- 298. Hyperaldosteronism
- 491. Pheochromocytoma
- 553. Renal artery stenosis
- Renal disease (e.g. late-stage 180. Diabetes mellitus, 508. Polyendocrine metabolic ovarian syndrome [formerly referred to as polycystic ovary syndrome], 262. Glomerulonephritis, 550. Reflux nephropathy)

Key considerations

- Accelerated hypertension and hypertension in the presence of acute cardiovascular events (hypertensive emergencies) require caution in rate of BP reduction
- Close to 50% of patients do not have adequate BP control
- Hypertension in pregnancy can be associated with placental insufficiency and fetal growth restriction
- Masked hypertension (normal BP in the clinic but elevated BP when measured at home or on 24-hour readings) is often an indicator of underlying cardiovascular disease
- Normal BP in pregnancy is lower than in the non-pregnant state
- Patients with 'white coat' hypertension need ongoing monitoring of BP and blood glucose
- The focus should be on managing all cardiovascular risk factors, not just BP, among patients with hypertension

Consideration of specific groups

- For children, it is important to distinguish secondary from primary hypertension, and to use age-specific criteria
- Pregnant women may experience chronic hypertension, gestational hypertension, preeclampsia (including HELLP [haemolysis, elevated liver enzymes, low platelet count] syndrome), eclampsia

See also

- [Anxiety >](#)
- [Dizziness, light-headedness and vertigo >](#)
- [Snoring >](#)

60. Indigestion and heartburn

Overview

Indigestion (discomfort or bloating below the diaphragm) is very common, yet can be the harbinger of serious disease. Gastro-oesophageal reflux disease (GORD), or heartburn, with discomfort above the diaphragm, is frequently related to lifestyle or obesity, but needs to be differentiated from cardiac causes.

Indicative causes

Common

- 16. Alcohol excess and 17. alcohol use
- Diet
- 237. Food intolerance
- 245. Gastritis (e.g. from alcohol, non-steroidal anti-inflammatory drugs [NSAIDs])
- 246. Gastro-oesophageal reflux disease
- 336. Irritable bowel syndrome
- 189. Drug side effects (e.g. NSAIDs, bisphosphonates)
- 425. Non-ulcer dyspepsia
- 427. Obesity
- Overeating
- 519. Pregnancy

Not so common, though not to miss

- 67. Barrett oesophagus
- Epigastric pain associated with 518. Preeclampsia
- 409. Myocardial ischaemia
- Oesophageal motility disorders (e.g. diffuse oesophageal spasm, 6. Achalasia)
- Rebound after proton-pump inhibitor withdrawal
- Serious intra-abdominal disease (e.g. 248. Gastrointestinal cancer [upper], 128. Choledocholithiasis)

Key considerations

- Symptomatic treatment alone may mask serious underlying disease
- Symptoms can mimic those of myocardial ischaemia

Consideration of specific groups

- Pregnant women commonly experience GORD

See also

- [Abdominal and loin pain >](#)
- [Chest discomfort and pain >](#)
- [Nausea and vomiting >](#)
- [Vomiting blood >](#)

61. Infertility

Overview

It is estimated that up to one in six Australian couples are infertile. Infertility can be primary or secondary, and is defined as an inability to conceive after 12 months of unprotected sexual intercourse. If the woman's ovarian reserve is reduced due to age, early referral is indicated. There are multiple reasons for infertility and often the cause cannot be found.

Many couples suffering infertility problems can be successfully treated with medical or surgical techniques, or with lifestyle changes. When this is unsuccessful, assisted reproductive technology (ART) may be used. ART can be a very stressful process and couples require support.

Use of ART is regulated by different legislation across Australian states and territories. Paid surrogacy is illegal in Australia.

Indicative causes

Common

- **Coital infrequency or technique**
 - 196. Dyspareunia or vaginismus
- **Female factors**
 - Anovulation (e.g. 508. Polyendocrine metabolic ovarian syndrome [formerly referred to as polycystic ovary syndrome])
 - 30. Anti-sperm antibodies
 - 211. Endometriosis
 - 474. Pelvic adhesions
 - 475. Pelvic inflammatory disease
 - Uterine abnormalities
- **Male factors**
 - 62. Azoospermia, 436. Oligospermia or 4. Abnormal sperm morphology
 - 219. Erectile disorders

Not so common, though not to miss

- 124. Cervical stenosis
- Maternal or paternal aneuploidy or genetic carrier status
- 520. Premature menopause

Key considerations

- Ovarian hyperstimulation is a serious complication of infertility treatment. It requires early identification and supportive measures including analgesia, fluid management and thromboprophylaxis to prevent further adverse events.

Common pitfalls

- Not considering combined male and female causes
- Not referring for specialist fertility care

Consideration of specific groups

- Obese women
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

See also

- [Sexual dysfunction >](#)

62. Involuntary movements

Overview

Motor function can be altered in several different ways, involving either a paucity or excess of movement. Involuntary movements may be spontaneous (at rest), postural or with intention only. These include dyskinesias, choreoathetosis, ballismus, tremors, tics and myoclonic jerks. A gradual onset suggests the possibility of a neurodegenerative disorder, whereas sudden onset raises the possibility of cerebrovascular causes.

Indicative causes

Common

- 116. Cerebral palsy
- 119. Cerebrovascular disease or cerebral injury
- 189. Drug side effects (e.g. lithium, caffeine, alcohol, valproate. Neuroleptics can cause Parkinsonism or tardive dyskinesia.)
- 469. Parkinson disease
- 558. Restless legs syndrome
- Tremor (e.g. 222. Essential tremor, 31. Anxiety-related)

Not so common, though not to miss

- Heavy metal toxicity in at-risk communities
- 295. Huntington chorea
- Metabolic derangements (e.g. 356. Liver failure)
- 621. Sydenham chorea
- 643. Tourette syndrome

Key considerations

- Acute problems can be associated with short-term involuntary movements (e.g. rigors, hypothermia, hyperventilation)

Common pitfalls

- Functional neurological disorder can be overlooked, but can also be inappropriately attributed as the cause
- Overlooking drug-induced movement disorders

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are at greater risk of rheumatic fever and therefore Sydenham chorea
- Foundry workers
- Mining communities

See also

- [Gait disturbance >](#)
- [Poisoning >](#)
- [Weakness—focal and generalised >](#)

63. Involuntary weight loss

Overview

Progressive unintentional (involuntary) weight loss is nearly always a sign of serious medical or mental illness and should be explored. Although weight loss among older people may be physiological, it can indicate underlying illness or a consequence of social circumstances.

Indicative causes

Common

- Dental disorders
- Medical conditions (e.g. chronic disease, swallowing disorders, 370. Malignancy, 302. Hyperthyroidism)
- Mental health conditions (e.g. 194. Eating disorder, 428. Obsessive–compulsive disorder, 31. Anxiety [including in childhood], 172. Depression, 428. Obsessive–compulsive disorder)
- Prolonged hospitalisation
- Reduced caloric intake (due to disability, poverty, social isolation or 615. Substance misuse)

Not so common, though not to miss

- 224. Factitious disorder by proxy (e.g. restrictive diets imposed by others)
- 302. Hyperthyroidism
- Infectious diseases (e.g. 287. Hepatitis, 258. Glandular fever, 655. Tuberculosis, 285. Helminthic infections, 294. HIV infection)
- 367. Malabsorption syndromes
- 189. Drug side effects

Key considerations

- Always consider occult malignancy in unexplained weight loss
- Elevated inflammatory markers can be a red flag

Common pitfalls

- Not considering malnutrition or concomitant nutrient deficiencies (e.g. iron, B12, folic acid, zinc, iodine, calcium, protein)
- Not differentiating between involuntary and voluntary weight loss

Consideration of specific groups

- In communities where failure to thrive is common (e.g. lower socioeconomic groups), the low weight of babies may incorrectly be regarded as normal and therefore under-recognised by that community

See also

- [Voluntary weight loss >](#)

64. Irritable infant

Overview

Irritability among children is a variable mixture of features (e.g. failure to settle normally, altered cry, abnormal response to minor stimuli). Although it is a non-specific feature, it may indicate underlying disease, particularly if accompanied by other clinical manifestations (e.g. fever, drowsiness, reduced mobility, pallor, bruising). Irritability is most commonly associated with acute infection, but may also be present in non-infectious conditions. Infants with nasal congestion are often irritable while feeding.

Indicative causes

Common

- 237. Food intolerance
- 246. Gastro-oesophageal reflux disease with 435. Oesophagitis
- 316. Infantile colic
- 452. Otitis media
- Unrecognised injury
- 663. Urinary tract infection
- 685. Viral upper respiratory tract infection

Not so common, though not to miss

- Congenital and genetic conditions
- 332. Intussusception
- 335. Iron deficiency anaemia
- 340. Juvenile idiopathic arthritis
- 352. Leukaemia
- 386. Meningitis and 208. Encephalitis
- 423. Non-accidental injury, including fractures and 329. Intracranial lesions and bleeds
- 447. Osteomyelitis or 584. Septic arthritis
- 687. Vitamin D deficiency (especially with rickets)

Key considerations

- For acute cases, consider central nervous system or musculoskeletal infection if febrile, or injury if afebrile
- For subacute or chronic cases, assess whether irritability is associated with pain
- Patterns of irritability and associated features (e.g. persistent or intermittent, pallor, sweating, refusal to bear weight, lateralising features, joint swelling) are important
- Physical findings may be overlooked if not specifically sought (e.g. reduced range of rotation in early septic arthritis of the hip)

Common pitfall

- Assuming that the problem is teething without adequate further assessment

See also

- [Febrile child >](#)

65. Jaundice

Overview

The appearance of jaundice is due to hyperbilirubinaemia, and may be caused by biliary obstruction, overproduction of bilirubin or impaired conjugation of bilirubin.

Indicative causes

Common

- 78. Biliary obstruction (e.g. 128. Choledocholithiasis, 464. Pancreatic cancer)
- 136. Cirrhosis
- 189. Drug side effects (e.g. flucloxacillin), 16. Alcohol excess or 17. Alcohol use
- Hepatic metastases
- Impairment of conjugation (e.g. Gilbert's syndrome)
- 318. Infection (e.g. viral 287. Hepatitis)
- Liver infiltration (e.g. 424. Non-alcoholic steatohepatitis)
- Neonatal
 - Physiological
 - ABO blood type incompatibility
 - 306. Hypothyroidism
 - Glucose-6-phosphate dehydrogenase (G6PD) deficiency

Not so common, though not to miss

- Acute fatty liver of pregnancy
- 76. Biliary atresia among infants
- 273. Haemolysis (haemolytic anaemia)
- 274. Haemolytic disease of the newborn
- 288. Herbal preparation side effects (e.g. comfrey tea)
- Impaired bilirubin uptake (e.g. 282. Heart failure)
- Intrahepatic 129. Cholestasis of pregnancy
- 583. Sepsis

Key considerations

- Evaluation of liver function tests will often help determine the underlying pathophysiology

Common pitfall

- Jaundice may be missed in people with darker skin

Consideration of specific groups

- Among newborns, unconjugated jaundice is common and usually physiological. Conjugated jaundice indicates a significant problem which requires further assessment.
- Pregnant women

See also

- [Abdominal and loin pain >](#)

66. Joint problem

Overview

Patients with joint problems can present with pain, swelling, reduced function and/or restricted movement. Pain involving a single joint, with limitation of movement, is a common presenting symptom. Pain involving several joints often suggests a systemic or metabolic disorder that might also have extra-articular manifestations. Symmetry and distribution of involved joints helps diagnosis. Degenerative arthropathies affect independence, so management of functional consequences is as important as managing the underlying disease.

Indicative causes

Common

- 104. Capsulitis and bursitis (e.g. frozen shoulder)
- 131. Chondromalacia patellae
- 178. Developmental dysplasia of the hip among children
- 182. Dislocations and fractures
- 266. Gout and pseudogout
- 337. Irritable hip or transient synovitis among children
- 443. Osteoarthritis
- 569. Rheumatoid arthritis
- 629. Tendinopathies and enthesopathies (e.g. 194. Dupuytren contracture, 653. Trigger finger)
- 649. Trauma (e.g. meniscal tear, ligament rupture, sports injuries)

Not so common, though not to miss

- 61. Avascular necrosis (e.g. hip)
- 272. Haemarthrosis can occur among people with a bleeding diathesis, or who take anticoagulant medication
- 318. Infection (e.g. 584. Septic arthritis, 209. Endocarditis)
- 419. Neuropathic joint (e.g. Charcot)
- 59. Autoimmune and connective tissue diseases (e.g. 340. Juvenile idiopathic arthritis, systemic lupus erythematosus, 533. psoriasis, vasculitis)
- 489. Perthes disease among children
- Reactive (e.g. 567. Rheumatic fever, 515. Post-viral arthritis, enteric inflammation, 586. Sexually transmissible infections, 320. Inflammatory bowel disease, 322. Insect-borne viruses)
- 574. Sarcomas
- 594. Slipped femoral epiphysis

Key considerations

- Early detection and treatment of infective arthritis minimises permanent damage
- Inflammatory arthropathies are important to identify since disease-modifying drugs can decrease morbidity and benefit long-term function
- Joint problems can sometimes reflect a problem elsewhere (e.g. reactive arthritides, referred pain, problem in an adjacent joint)
- Migratory polyarthropathy suggests a reactive arthritis (e.g. rheumatic fever)

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are at significantly increased risk of rheumatic fever
- Obesity predisposes to osteoarthritis
- People with diabetes mellitus are at greater risk of arthropathies and tendon ruptures

See also

- [Bone pain >](#)
- [Fracture or dislocation >](#)
- [Limb swelling >](#)
- [Muscle or soft tissue pain >](#)

67. Limb swelling

Overview

Limb swelling most commonly occurs in the legs. Causes are usually systemic when bilateral, and local when unilateral.

Indicative causes

Common

- 105. Cardiac failure or fluid overload
- 171. Dependent oedema from prolonged sitting
- 318. Infection (bacterial, viral, fungal)
- 189. Drug side effects (e.g. nifedipine, fludrocortisone)
- Post-operative
- 519. Pregnancy
- 649. Trauma
- 670. Varicose veins and chronic venous insufficiency
- 681. Venous thrombosis

Not so common, though not to miss

- 19. Allergic reaction
- Associated with 518. Preeclampsia
- 164. Deep vein thrombosis (DVT)—spontaneous or associated with risk factors (e.g. flying, surgery)
- 214. Envenomation
- 304. Hypo-albuminaemia (e.g. 356. Liver failure, 416. Nephrotic syndrome, 373. Malnutrition)
- 363. Lymphatic obstruction (e.g. post-surgical)
- Pelvic or 565. Retroperitoneal obstruction

Key considerations

Common pitfalls

- Assuming that DVT is unilateral when it could be bilateral
- Giving a systemic treatment for localised cause (e.g. diuretic for dependent oedema)
- Failing to consider a drug cause

See also

- [Joint problem >](#)
- [Muscle or soft tissue pain >](#)

68. Mood dysfunction

Overview

Mood refers to a person's emotional state over a period of time. Mood disorders include depression, hypomania and mania, and are sometimes associated with psychotic symptoms. Transient feelings of sadness or elation are a normal human experience.

Depressive illness is common, and patients sometimes present with somatic symptoms (e.g. fatigue, pain, memory loss, insomnia, changes in appetite). Hypomania and mania are less common, and refer to persistently elevated, expansive or irritable mood with associated symptoms and signs.

Indicative causes

Common

- 13. Adjustment disorder with depressed mood
- 79. Bipolar affective disorder
- 366. Major depressive disorder
- 487. Persistent depressive disorder (dysthymia)
- 488. Personality disorder
- 516. Postnatal mood disorder

Not so common, though not to miss

- Catatonia
- Mood disorders due to a medical condition
- 514. Post-traumatic stress disorder
- 527. Prolonged grief disorder
- 576. Schizoaffective disorder
- 616. Substance- or medication-induced mood disorder

Key considerations

- Adverse life events (e.g. childhood sexual abuse, sexual assault, domestic violence, significant losses, torture) predispose individuals to mood disorders
- All mood disorders are major risk factors for suicidal ideation and death by suicide
- Always enquire about use of alcohol and other drugs in mood disorders
- Consider depressive illness among patients with recurrent or unusual somatic symptoms
- Differentiate between normal grief, prolonged grief disorder and depressive illness
- High comorbidity of depression with personality disorders
- People with access to lethal means are at greater risk of death by suicide (e.g. police officers, doctors, farmers)

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may experience altered mood as a response to historical events, or that are specific to their spiritual and cultural beliefs, and therefore this may be culturally appropriate
- People exposed to childhood traumatic events, loss of culture and loss of family are at increased risk for mood disorders; particular groups include:
 - Aboriginal and/or Torres Strait Islander people
 - asylum seekers, refugees and migrants
- Prisoners' socioeconomic backgrounds or life experiences often place them at increased risk for mood disorders

See also

- [Abnormal thoughts and perceptions >](#)
- [Anxiety >](#)
- [Self-harm and suicidal behaviour >](#)
- [Substance misuse and addiction >](#)

69. Mouth or throat problem

Overview

Conditions of the mouth or throat may be localised or reflect a systemic condition. They may be diagnosed and managed by medical and/or dental practitioners.

Sore throat is most commonly associated with an upper respiratory tract infection, usually viral. Group A streptococcal infections of the throat, particularly among Aboriginal and/or Torres Strait Islander patients, are important to detect and treat because of their association with rheumatic fever and post-streptococcal glomerulonephritis.

Indicative causes

Common

- 170. Dental caries
- 318. Infection (e.g. 493. Pharyngitis, 347. Laryngitis, 639. Tonsillitis, 158. Croup, 290. Herpes stomatitis)
- 482. Periodontal disease
- 625. Teething
- 649. Trauma (mechanical or chemical)
- 399. Mouth ulcers

Not so common, though not to miss

- 24. Anaphylaxis may lead to rapid occlusion of the airway
- 27. Angioedema
- 358. Lower respiratory tract infection (e.g. bacterial tracheitis)
- 71. Behçet disease
- Congenital anomalies (e.g. 90. Branchial cyst)
- 217. Epiglottitis
- 238. Foreign body aspiration or 239. Foreign body trauma (e.g. fishbone)
- 370. Malignancy
- 586. Sexually transmissible infection, including primary 622. Syphilis
- 607. Stevens–Johnson syndrome

Key considerations

- Non-healing ulcer may signal underlying malignancy
- Stridor at rest may indicate a significant risk of airway obstruction, which can be exacerbated by examination

Common pitfalls

- Not considering the impact on nutrition
- Inappropriate use of antibiotics for sore throats

Consideration of specific groups

- Groups at risk of post-streptococcal complications include:
 - Aboriginal and/or Torres Strait Islander people
 - Māori people
 - Pacific Islander people
 - people in overcrowded living circumstances
- Smokers have increased risk of oropharyngeal cancer

See also

- [Bad breath >](#)
- [Difficulty breathing—shortness of breath >](#)
- [Difficulty breathing—wheezing or noisy breathing >](#)
- [Difficulty speaking and hoarseness >](#)
- [Difficulty swallowing >](#)
- [Dry mouth >](#)
- [Snoring >](#)
- [Toothache >](#)

70. Muscle or soft tissue pain

Overview

Muscular or soft tissue pain should be differentiated from joint or bone pain. Trauma or injury is often obvious, but identification of other causes may be informed by location (local, regional or general) and time course (acute, intermittent or chronic). Associated symptoms must be considered (e.g. weakness, localised tenderness, rash).

Indicative causes

Common

- 143. Complex regional pain syndrome
- 189. Drug side effects (e.g. statins), 190. Drug use (e.g. opioids) or 191. Drug withdrawal
- Exercise and overuse syndromes
- Ischaemia (e.g. venous or 43. Arterial insufficiency)
- Limb 156. Cramps (e.g. 165. Dehydration, 519. Pregnancy)
- Localised infection (e.g. 5. Abscess, 112. Cellulitis)
- 406. Myalgia
 - 318. Infection (e.g. viraemia)
 - 509. Polymyalgia rheumatica
 - 132. Chronic fatigue syndrome
 - 235. Fibromyalgia
- Referred pain (e.g. 417. Nerve compression and entrapment, joint disorder, 291. Herpes zoster/shingles)
- 629. Tendinopathies and enthesopathies (e.g. 212. Enthesitis, 628. Tendon rupture)
- 649. Trauma (e.g. 605. Sprains, 608. Strains, penetrating injuries, bruising)

Not so common, though not to miss

- Endocrine (e.g. thyroid, 180. Diabetes mellitus)
- Inflammatory (e.g. 510. Polymyositis, 177. Dermatomyositis)
- 410. Myopathy
- Neurodegenerative
- 687. Vitamin D deficiency

Key considerations

Common pitfalls

- Delay in diagnosis of a serious infection or other systemic illness
- Not considering non-accidental injury
- Not considering referred pain
- Not examining joints for associated pathological features

Consideration of specific groups

- Non-accidental injury among children, older people, and people with cognitive impairment or disability

See also

- [Back and neck pain >](#)
- [Bone pain >](#)
- [Calf, thigh and buttock pain on walking >](#)
- [Domestic violence, abuse and neglect >](#)
- [Joint problem >](#)
- [Limb swelling >](#)
- [Trauma—physical >](#)

71. Nail abnormality

Overview

Although many nail problems are local in origin, some are a sign of an underlying medical condition.

Indicative causes

Common

- Chemical staining (e.g. nicotine)
- 242. Fungal infection
- Ingrown toenail
- 437. Onychogryphosis
- 470. Paronychia
- 649. Trauma (e.g. nail biting, subungual haematoma, nailbed injury)

Not so common, though not to miss

- Clubbing
- 343. Koilonychia
- 355. Liver disease (e.g. leukonychia)
- 426. Nutritional deficiencies
- Onycholysis (e.g. thyroid disease)
- 533. Psoriasis (e.g. pitting)
- Splinter haemorrhages

Key considerations

- The presence of Beau's lines caused by temporary cessation of nail growth may indicate a present or previous systemic problem (e.g. chemotherapy, nutritional deficiency, stress) or local trauma

See also

- [Skin lesions >](#)

72. Nausea and vomiting

Overview

Nausea and vomiting are usually a manifestation of a systemic, local or central illness and are therefore not diagnostic in isolation. The nature of the vomitus (e.g. bile, blood) may give clues to underlying disease.

Indicative causes

Common

- 165. Dehydration
- 189. Drug side effects (e.g. antibiotics, alcohol, opioids, anaesthetics, chemotherapy)
- 237. Food intolerance
- 246. Gastro-oesophageal reflux disease (including among infants)
- 247. Gastroenteritis
- 679. Hypotension (e.g. vasovagal)
- 344. Labyrinthitis
- Mental health condition (e.g. 31. Anxiety, 199. Eating disorder/bulimia, overeating)
- 392. Migraine
- 397. Motion sickness
- Pain
- 519. Pregnancy
- Systemic illness (e.g. 318. Infection)

Not so common, though not to miss

- 250. Gastrointestinal tract obstruction (e.g. due to 102. Cancer, hernia, ileus, bariatric surgery)
- 299. Hyperemesis gravidarum
- 374. Malrotation with volvulus in infant
- 457. Ovarian torsion
- 541. Pyloric stenosis among infants
- 543. Raised intracranial pressure
- 617. Sunstroke

Key considerations

- Assess for dehydration and electrolyte abnormalities
- Consider need for infection control and management of public health risk
- Some cases will be self-limiting and may not require investigation

Consideration of specific groups

- Small amounts of regurgitation is normal in babies

See also

- [Abdominal and loin pain >](#)
- [Abdominal swelling, lump and bloating >](#)
- [Altered bowel function >](#)
- [Indigestion and heartburn >](#)
- [Vomiting blood >](#)

73. Neck lump

Overview

Neck lumps or swellings are relatively common among all age groups. The most common causes of neck lumps are lymph node and thyroid gland enlargement. Underlying malignancy should be considered. Localised enlarged lymph nodes should prompt examination for generalised lymphadenopathy, as this raises other diagnostic possibilities.

Indicative causes

Common

- 362. Lymphadenopathy (lymph node enlargement)
 - Acute localised infection (e.g. 493. Pharyngitis)
 - 684. Systemic viral infection (e.g. Epstein–Barr virus, cytomegalovirus)
- 259. Thyroid enlargement

Not so common, though not to miss

- 5. Abscess
- Congenital (e.g. 90. Branchial cyst, 636. Thyroglossal cyst)
- 215. Epidermoid cyst
- 362. Lymphadenopathy (lymph node enlargement)
 - Autoimmune disease (e.g. systemic lupus erythematosus)
 - Chronic infection (e.g. 655. Tuberculosis, 294. HIV infection)
 - 189. Drug side effects (e.g. phenytoin)
 - 364. Lymphoid malignancy (e.g. non-Hodgkin lymphoma)
 - 391. Metastatic malignancy
 - Rare systemic diseases (e.g. 341. Kawasaki disease)
 - 573. Sarcoidosis
- 572. Salivary gland obstruction or neoplasm
- Torticollis among children

Key considerations

Common pitfalls

- Failure to examine beyond the neck
- Failure to examine the oropharynx and dentition to exclude an underlying cause

Consideration of specific groups

- People from countries with high risk of tuberculosis

See also

- [Difficulty swallowing >](#)
- [Mouth or throat problem >](#)

74. Nose problem

Overview

Nose problems include blockage, bleeding, discharge and fracture. The common cold and allergies are the most frequent causes of acute rhinorrhoea. Epistaxis is often caused by nose picking, but can be the first manifestation of a haematological disorder.

Indicative causes

Common

- Allergy (278. Hayfever)
- 142. Common cold
- 362. Lymphadenopathy (e.g. enlarged adenoids)
- 414. Nasal polyp
- 189. Drug side effects (e.g. rebound from overuse of nasal sprays)
- 589. Sinusitis
- 649. Trauma (e.g. fracture)

Not so common, though not to miss

- 81. Bleeding disorders as a cause of epistaxis
- 118. Cerebrospinal fluid (CSF) leak
- 238. Foreign body aspiration or 239. Foreign body trauma
- 415. Nasopharyngeal tumours
- 190. Drug use (e.g. snorting drugs such as cocaine)

Key considerations

- CSF leak (e.g. due to head injury or malignancy) can cause persistent clear rhinorrhoea
- Septal deviation is frequently asymptomatic

See also

- Foreign body—[orifice >](#)
- Snoring [>](#)

75. Numbness and tingling

Overview

Numbness and tingling may be localised due to a specific nerve lesion. A more generalised and/or symmetrical distribution suggests a systemic or central cause. Symptoms due to transient compression of a peripheral nerve are common and usually of no significance.

Indicative causes

Common

- 115. Cerebral hemisphere lesion (e.g. 647. Transient ischaemic attack, 610. Stroke)
- Herpes infection (291. Herpes zoster/shingles, 289. Herpes simplex)
- 303. Hyperventilation
- 417. Nerve compression and entrapment (e.g. 108. Carpal tunnel syndrome, 578. Sciatica)
- 481. Peripheral neuropathy (e.g. 180. Diabetes mellitus, 17. Alcohol use, 189. Drug side effects [chemotherapy])

Not so common, though not to miss

- 350. Leprosy
- 392. Migraine
- 544. Raynaud disease
- 601. Spinal cord lesion (e.g. 402. Multiple sclerosis, 623. Syringomyelia, metastases)
- 505. Poisoning (e.g. heavy metals)
- 687. Vitamin B12 deficiency

Key considerations

Common pitfalls

- Failure to consider an underlying systemic cause
- Failure to recognise when a proposed diagnosis is inconsistent with underlying neuroanatomical findings

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may be at risk of developing peripheral neuropathy due to a higher prevalence of diabetes
- Carpal tunnel syndrome is common among pregnant women, but may resolve spontaneously after birth

See also

- [Gait disturbance >](#)
- [Weakness—focal and generalised >](#)

76. Obesity

Overview

Obesity is a chronic condition that is a major contributor to health problems and is increasing in prevalence. The causes are multifactorial, including genetic, physiological, behavioural, cultural and environmental factors.

There is an increased risk of malignancy and comorbid chronic illnesses (e.g. diabetes mellitus, hypertension, atherosclerosis, sleep apnoea, depression).

Indicative causes

Common

- Dietary and lifestyle factors
- Environments that encourage eating and do not stimulate activity
- Genetic factors
- 189. Drug side effects (e.g. psychotropics, antiepileptics, steroids)

Not so common, though not to miss

- 159. Cushing syndrome
- 199. Eating disorder (binge eating without compensation)
- 253. Genetic developmental disorders
- 268. Growth hormone deficiency
- 306. Hypothyroidism

Key considerations

- Childhood abuse and/or neglect can be a risk factor for adult obesity
- Nutrient deficiencies (e.g. protein, iron, B12, calcium, iodine, zinc) can occur among overweight people due to inadequate or idiosyncratic intake
- Obesity is a major risk factor for fetal, obstetric and perinatal complications
- Obesity is associated with stigma and weight discrimination
- Obesity is complex and involves attention to psychological, social and cultural considerations, and not just diet and lifestyle
- Obesity issues in childhood can persist with sequelae in adult life
- Use appropriate body mass index (BMI) for age growth charts when assessing children; BMI criteria vary with age

Consideration of specific groups

- Exposure to inequity can adversely influence healthy life choices and lessen access to healthy food and health care, creating a greater risk of obesity
- People who have had gastric bypass surgery for weight loss are at increased risk of malnutrition (including vitamin deficiencies) because of malabsorption
- Pregnant women
- Some cultures value being overweight as a sign of wealth and power
- Women with polyendocrine metabolic ovarian syndrome (formerly referred to as polycystic ovary syndrome) and infertility

See also

- [Childbirth >](#)
- [Infertility >](#)
- [Joint problem >](#)
- [Pregnancy >](#)
- [Well person check and screening >](#)

77. Obsessional thinking and compulsive behaviour

Overview

Obsessive thinking involves recurrent, distressing thoughts and images. The degree and nature vary from worry to ruminations through to obsessions. Worry is anxious preoccupation with anticipated events, and can be part of normal problem-solving when not excessive. Rumination involves a preoccupation with past events, and is associated with feelings of guilt, regret and anger. Obsessions are thoughts, images or impulses that are repetitive, stereotypical and distressing. Common compulsions are handwashing, checking, counting or arranging rituals.

Obsessions and compulsions cause significant distress and interfere with daily activities. Although patients with these disorders do recognise they are their own thoughts, these thoughts are involuntary and unwanted and patients try to resist them.

Indicative causes

Common

- Anxiety disorders (e.g. 252. Generalised anxiety disorder, 595. Social anxiety disorder)
- 79. Bipolar affective disorder
- 172. Depression
- 199. Eating disorder
- 428. Obsessive–compulsive disorder (OCD)
- 615. Substance misuse and dependence

Not so common, though not to miss

- 84. Body dysmorphic disorder
- Obsessions and rituals are a key diagnostic feature of 57. Autism spectrum disorder
- 514. Post-traumatic stress disorder
- 596. Somatic symptom disorder
- Specific 495. Phobia

Key considerations

- Obsessional thinking or compulsions can be mistaken for schizophrenia
- OCD can impair daily work and social functioning, and reduce quality of life
- People with OCD have an increased risk of suicide
- People with OCD often have comorbid mental health disorders (e.g. anxiety disorders, depression, substance misuse, tic disorders) and health conditions related to their compulsive behaviours (e.g. contact dermatitis from frequent handwashing)
- Ruminations typically occur in depression

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may experience thoughts or perceptual phenomena that are specific to their spiritual and cultural beliefs, and therefore these may be culturally appropriate

See also

- [Abnormal thoughts and perceptions >](#)
- [Anxiety >](#)
- [Mood dysfunction >](#)
- [Self-harm and suicidal behaviour >](#)
- [Substance misuse and addiction >](#)

78. Palpitations

Overview

Palpitations, subjective awareness of an abnormal heartbeat, may be due to changes in rate, rhythm and/or force of heartbeats. Patients can usually distinguish palpitations that are occasional, continuous, regular or irregular. Palpitations are commonly associated with anxiety and vasodilatory disorders but may indicate a more serious cardiac arrhythmia, particularly when associated with other cardiovascular symptoms.

Indicative causes

Common

- 22. Anaemia causing tachycardia
- 31. Anxiety
- Cardiac rhythm disturbance
 - 54. Atrial fibrillation and 55. Atrial flutter
 - 201. Ectopic beats
 - 619. Supraventricular tachycardia
 - 682. Ventricular tachyarrhythmias
- 206. Electrolyte disturbances
- Fever
- Predisposing cardiac causes (e.g. 107. Cardiomyopathy, 339. Ischaemic heart disease, 480. Pericarditis, congenital defects, 567. Rheumatic fever, 318. Infection, 357. Long QT syndrome)
- 637. Thyrotoxicosis
- 190. Drug use and 191. Drug withdrawal (e.g. caffeine, nicotine, alcohol, illicit drugs including cocaine and amphetamines)

Key considerations

- Serious cardiac arrhythmias are usually associated with symptoms

Common pitfalls

- Not defining the electrocardiogram abnormality
- Not looking for the underlying cause

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people have a high burden of rheumatic heart disease and ischaemic heart disease

See also

- [Anxiety >](#)
- [Cardiopulmonary arrest >](#)
- [Faintness and collapse >](#)

79. Pelvic pain

Overview

Pelvic pain is often functionally disabling. Although it can have intra-abdominal or retroperitoneal causes, the aetiology is usually gynaecological.

Indicative causes

Common

- **Gastrointestinal**
 - 40. Appendicitis
 - 150. Constipation
 - 185. Diverticular disease
 - 336. Irritable bowel syndrome
- **Gynaecological**
 - 195. Dysmenorrhoea
 - 211. Endometriosis
 - 454. Ovarian cyst haemorrhage or rupture
 - 457. Ovarian torsion
 - 462. Ovulation pain
 - 475. Pelvic inflammatory disease or 5. Abscess
- **Pregnancy-related**
 - 202. Ectopic pregnancy
 - 394. Miscarriage
- **Urinary**
 - 318. Infection (bacterial, viral, fungal)
 - 658. Ureteric calculi or 80. Bladder calculi

Not so common, though not to miss

- 232. Fibroid degeneration in pregnancy
- 456. Ovarian malignancy
- Primary amenorrhoea due to congenital malformations of the genital tract (e.g. imperforate hymen)
- 649. Trauma (e.g. 585. Sexual abuse, sexual activity, 238. Foreign body aspiration, 239. Foreign body trauma)

Key considerations

- Important diagnoses that require urgent attention include ectopic pregnancy, ovarian torsion or appendicitis
- Somatic symptoms may be related to, or worsened by, life stressors

See also

- [Abdominal and loin pain >](#)
- [Altered bowel function >](#)
- [Vaginal bleeding >](#)
- [Vaginal discharge >](#)

80. Poisoning

Overview

Poisoning can occur by ingestion, inhalation, transdermal absorption or percutaneous injection. It can be accidental, intentional or iatrogenic. Some substances are only toxic in excess quantities or for a prolonged period. Some substances will be toxic with minimal exposure in susceptible people or at particular ages. Poisons can have an impact on any system of the body.

Identification of the poison and how it has affected the patient is an essential first step.

Indicative causes

Common

- Accidental poisoning, particularly among children
- Occult environmental poisoning (e.g. lead, gas leaks)

Not so common, though not to miss

- Environmental or occupational chemical exposure
- Haematological or neurological abnormalities caused by toxins

Key considerations

- Each state and territory has a poison information centre that can provide advice on risk and management

Common pitfalls

- Not considering contaminants, or other active ingredients, in recreational substances (including in vapes)
- Not considering self-administered substances
- Not investigating for poisons among people with non-specific symptoms that do not abate (e.g. fatigue)

Consideration of specific groups

- Occupational (e.g. mining, farmers)

See also

- [Self-harm and suicidal behaviour >](#)
- [Substance misuse and addiction >](#)

81. Pregnancy

Overview

Pregnancy is generally a normal, healthy condition. However, in some cases pregnancy can cause a pathological state or exacerbate a pre-existing medical condition. There are two patients in pregnancy—the mother and the fetus. Legally, the mother's health and wellbeing have priority over that of the fetus.

Pregnancy care includes pre-pregnancy counselling, antenatal care, birth and the 6-week postnatal period. The role of the medical practitioner is to maintain health, and to recognise and treat disease. It is important to be aware of various models of care to facilitate appropriate referral, ensuring suitable treatment is provided with efficient use of resources. Multidisciplinary care is sometimes required, especially for complex cases.

Pregnancy may be accompanied by minor ailments, many of which are associated with the physiological changes that occur.

Common minor complaints

- Aching legs
- 63. Backache
- Breast tenderness
- 227. Fatigue
- 246. Gastro-oesophageal reflux disease
- Nausea
- Pain from pelvic ligament laxity
- Painful thrombosed 276. Haemorrhoids and vulval varicosities
- Urinary frequency
- 670. Varicose veins

Other more serious complications

- Abnormal site of the pregnancy
- 129. Cholestasis of pregnancy
- Gestational 180. Diabetes mellitus
- 301. Hypertension and 518. Preeclampsia, including HELLP (haemolysis, elevated liver enzymes, low platelet count) syndrome and 200. Eclampsia
- Intrauterine infection
- Malpresentation of the fetus
- Missed 394. Miscarriage—the presence of a non-viable pregnancy without pain or bleeding; sometimes there is an associated reduction in symptoms of pregnancy
- 400. Multiple gestation

- Placental abnormalities
 - 498. Placental abruption
 - 497. Placenta previa or accreta
- 513. Postpartum haemorrhage—primary or secondary
- 604. PPRM (preterm prelabour rupture of membranes)
- Preterm labour
- 566. Rhesus isoimmunisation

Key considerations

Common pitfalls

- Attributing symptoms to pregnancy without considering other causes
- Dismissing or misdiagnosing other conditions (e.g. appendicitis, urinary tract infection, breast cancer) because it is incorrectly attributed to the pregnancy or because pregnancy alters how the condition manifests
- Not considering the possibility of pregnancy in every woman of reproductive age
- When prescribing, not considering the possibility of pregnancy or the impact on the fetus

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may consider pregnancy to be family business, so some decision making may need to include additional people
- Grand multiparous women
- Older women
- Teenagers
- Women who are obese or underweight
- Women who use drugs or alcohol during pregnancy
- Women whose pregnancy has resulted from assisted reproductive technology treatment

See also

- [Abdominal and loin pain >](#)
- [Childbirth >](#)
- [Preterm labour >](#)

82. Preterm labour

Overview

Preterm labour is defined as labour occurring at less than 37 weeks' gestation. Prematurity is the leading cause of neonatal mortality and morbidity in Australia, with two-thirds of preterm births occurring spontaneously. The most common indications for inducing labour or caesarean section before 37 weeks' gestation are preeclampsia and fetal growth restriction.

Indicative causes

Common

- 29. Antepartum haemorrhage, especially 498. Placental abruption
- Cervical issues (e.g. history of cervical excisional procedures or cervical trauma, second-stage caesarean section, history of multiple dilatation and curettage procedures)
- 148. Congenital uterine anomaly
- History of preterm birth or mid-trimester pregnancy loss
- 318. Infection (e.g. chorioamnionitis, 663. Urinary tract infection, 40. Appendicitis)
- Low socioeconomic status and associated factors (e.g. smoking, low pre-pregnancy weight)
- Maternal connective tissue disorders (e.g. Ehlers–Danlos syndrome)
- 459. Overdistension of the uterus (e.g. multiple pregnancy, polyhydramnios)
- PPROM (preterm prelabour rupture of membranes)

Key considerations

- Consider the indications for:
 - anaesthetic consultation before birth
 - antibiotics
 - bacterial swab
 - continuous fetal monitoring in labour
 - preterm birth risk stratification test (e.g. Actim® Partus)
 - MgSO₄ for fetal neuroprotection if < 30 weeks' gestation
 - neonatology consultation before birth
 - steroids (and potential impact on control of diabetes mellitus)
 - tocolysis
 - transfer to tertiary obstetric or neonatal unit
- Women with a short cervix in the mid-trimester who are otherwise low risk may benefit from cervical cerclage or vaginal progesterone

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people may consider birthing to be family business, so some decision making may need to include additional people

See also

- [Abdominal and loin pain >](#)
- [Childbirth >](#)
- [Pregnancy >](#)

83. Rectal bleeding and pain

Overview

Rectal blood loss can originate from any site in the digestive tract. Patients may present with fresh blood or altered blood (melaena), depending on the site of origin, rapidity of blood loss and underlying cause.

Indicative causes

Common

- 23. Anal fissure
- 26. Angiodysplasia
- 185. Diverticular disease
- 276. Haemorrhoids
- 320. Inflammatory bowel disease
- 477. Peptic ulcer disease
- 547. Rectal cancer or 141. Colon cancer

Not so common, though not to miss

- 37. Aorto-duodenal fistula
- 211. Endometriosis
- 338. Ischaemic colitis
- 381. Meckel diverticulum
- 585. Sexual abuse
- 624. Systemic bleeding disorder
- 649. Trauma

Key considerations

- Rectal bleeding always requires a diagnosis
- There may be dual disease processes; for example:
 - anticoagulants may contribute to, but are unlikely causes of, gastrointestinal bleeding
 - haemorrhoids are very common, but should not necessarily be assumed to be the cause of rectal bleeding

Consideration of specific groups

- For children presenting with rectal bleeding, consider Meckel diverticulum or child abuse
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

See also

- [Altered bowel function >](#)
- [Bruising >](#)

84. Seizures and convulsions

Overview

Seizures can be isolated, associated with another illness, or part of an epilepsy syndrome. They can be focal or generalised, and therefore are not always associated with loss of consciousness. Seizures can occur due to cerebral irritation, systemic illness (particularly fever) or metabolic derangement.

Indicative causes

Common

- 18. Alcohol withdrawal
- Complication of 610. Stroke
- 218. Epilepsy
- Fever

Not so common, though not to miss

- 218. Epilepsy (absence [petit mal] seizures among children)
- Central nervous system infection (e.g. 208. Encephalitis, 386. Meningitis)
- 191. Drug withdrawal (e.g. benzodiazepine)
- 189. Drug side effects (e.g. bupropion, amphetamines)
- 200. Eclampsia
- 305. Hypoglycaemia
- 308. Hypoxic ischaemic encephalopathy among infants
- 317. Infantile spasms
- 329. Intracranial lesions and bleeds
- Psychogenic non-epileptic seizures (596. Somatic symptom disorder)

Key considerations

- An eyewitness account can be very helpful for diagnosis
- Febrile seizures among children are common and usually benign
- Seizure can be precipitated by syncope or arrhythmia
- Vasovagal or vasodepressor syncope may sometimes be difficult to differentiate from epilepsy

Common pitfall

- Overlooking drug withdrawal

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are at risk of under-diagnosis and under-treatment of epilepsy
- Pregnancy
- Seizures associated with breath-holding among infants
- Specific consulting skills and/or transfer to another healthcare facility are required for Aboriginal and/or Torres Strait Islander infants, as outlined in [Aboriginal and Torres Strait Islander views of health](#)

See also

- [Faintness and collapse >](#)
- [High blood pressure >](#)

85. Self-harm and suicidal behaviour

Overview

There is a spectrum of suicidal behaviour, ranging from risk-taking behaviour (e.g. driving without a seatbelt, not taking medication), non-suicidal self-harm, suicide attempts, through to death by suicide. Many suicide attempts are impulsive. People who self-harm are at an increased risk of death by suicide, and people who engage in suicidal behaviour may go on to make further attempts.

Indicative causes

Common

- 56. Attention deficit hyperactivity disorder
- 79. Bipolar affective disorder
- 86. Borderline and/or antisocial personality disorder
- Childhood history of physical, emotional or 585. Sexual abuse
- 199. Eating disorder
- 366. Major depressive disorder
- 577. Schizophrenia and 576. Schizoaffective disorder

Not so common, though not to miss

- 13. Adjustment disorder
- 57. Autism spectrum disorder
- 134. Chronic pain
- 230. Fetal alcohol spectrum disorder
- 323. Intellectual disability
- 486. Persistent complex bereavement disorder
- Postpartum psychosis (174. Depression with psychosis)
- 514. Post-traumatic stress disorder

Key considerations

- Exploring suicidal risk will not increase the risk of death by suicide, but can decrease the risk of death by suicide by identifying patients who have suicidal ideation or plans
- It is important to ask all patients who self-harm about suicidal ideation, plans, past attempts and family history

Consideration of specific groups

Groups at increased risk of death by suicide include:

- Aboriginal and/or Torres Strait Islander people
- asylum seekers, refugees and migrants
- members of cultural minority groups
- people living in rural and remote areas
- people who engage in problem gambling
- people with easy access to lethal means (e.g. health professionals, police, farmers)

See also

- [Mood dysfunction >](#)
- [Poisoning >](#)
- [Substance misuse and addiction >](#)

86. Sexual dysfunction

Overview

Sexual dysfunction prevents an individual or couple from experiencing satisfaction from sexual activity. Various factors can affect the cycle of libido, arousal and performance.

Indicative causes

Common

- 17. Alcohol use and 190. Drug use (marijuana)
- Chronic disease (e.g. 180. Diabetes mellitus, 673. Vascular disease, 427. Obesity)
- 189. Drug side effects (e.g. thiazides, beta blockers, SSRIs [selective serotonin reuptake inhibitors], antipsychotics)
- Mental health conditions (e.g. 172. Depression, 31. Anxiety, traumatic past experience)
- Pain or local disease (e.g. post-prostatectomy, 211. Endometriosis, 353. Lichen sclerosus, 255. Genitourinary syndrome of menopause, 318. Infection, interstitial cystitis)
- Psychosocial factors (e.g. 478. Performance anxiety, 609. Stress, 227. Fatigue, 552. Relationship problems)

Not so common, though not to miss

- Hormone deficiency, particularly 634. Testosterone deficiency among men

Key considerations

- Cultural factors such as gender role expectations and religious norms can affect sexual function
- Erectile dysfunction can be the first manifestation of cardiovascular disease or diabetes mellitus
- Victims of domestic violence may present with symptoms of sexual dysfunction

Consideration of specific groups

- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- The reasons for sexual dysfunction are similar among LGBTQI (lesbian, gay, bisexual, transgender, queer and intersex) people as those who do not identify with these groups

See also

- [Infertility >](#)
- [Urinary problem >](#)

87. Shock

Overview

Urgent treatment of a shocked hypotensive patient takes priority, and may be required before the cause is identified.

Indicative causes

Common

- Cardiogenic (e.g. 408. Myocardial infarction)
- Distributive (e.g. 561. Sepsis, 24. Anaphylaxis)
- Hypovolaemia (e.g. massive haemorrhage, severe burns)
- Obstructive (e.g. 631. Tension pneumothorax, 479. Pericardial tamponade)

Not so common, though not to miss

- 34. Aortic dissection
- Concealed haemorrhage (e.g. 564. Retroperitoneal bleed)

Key considerations

- This is a situation where help should be sought immediately

See also

- [Altered level of consciousness >](#)
- [Cardiopulmonary arrest >](#)
- [Faintness and collapse >](#)

88. Skin lesions

Overview

Skin and subcutaneous lesions are common. Although most focal skin lesions are benign, early recognition of premalignant and malignant lesions is essential. Australia has a high prevalence of skin cancer.

Indicative causes

Common

- 8. Acne
- 10. Actinic (solar) keratosis
- 240. Freckles
- 293. Hidradenitis suppurativa
- 318. Infection (e.g. 5. Abscess, 112. Cellulitis)
- Lumps
 - 161. Cysts
 - 176. Dermatofibroma
 - 236. Folliculitis
 - 244. Ganglia
 - 354. Lipoma
- 411. Naevi
- 581. Seborrheic keratosis
- 592. Skin tags
- Skin tumours (e.g. 384. Melanoma, 606. Squamous cell carcinoma, 69. Basal cell carcinoma)
- 686. Viral warts

Not so common, though not to miss

- 101. Bursae
- 5. Abscess (furuncles/carbuncles [boils])
- 271. Haemangioma
- 310. Impetigo
- Skin manifestations of a serious systemic infection (e.g. necrotising infections, meningococcal disease)

Key considerations

- Acne can have a significant psychological impact in adolescents

Common pitfalls

- Failure to consider melanoma in younger age groups or people with darker skin
- Melanoma can occur on areas not exposed to sun

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are at greater risk of furuncles and impetigo, and therefore increasing risk of other conditions including rheumatic heart disease
- Migrant populations are at increased risk of tropical disease infestations
- People with fair skin

See also

- [Nail abnormality >](#)
- [Skin rash and itch >](#)
- [Skin wounds, injuries and ulcers >](#)

89. Skin rash and itch

Overview

Generalised skin lesions including rashes, macules, papules, plaques, pustules and blisters are common. Most are not life-threatening, and usually self-limiting or episodic. Some rashes are the first indication of a serious infection, so further assessment is required when there are other clinical manifestations. Itch is not always associated with a rash and may be due to systemic disease.

Indicative causes

Common

- 19. Allergic reaction (e.g. drug reactions, insect bites, food, latex)
- 193. Dry skin
- 204. Eczema or 53. Atopic dermatitis
- 283. Heat rash or 524. Prickly heat (e.g. 393. Miliaria)
- 318. Infection
 - 237. Fungal (e.g. 638. Tinea, candida)
 - 310. Impetigo and bacterial (e.g. *Streptococcus* spp., *Staphylococcus* spp.)
 - Parasitic (e.g. 575. Scabies, 280. Head lice)
 - Viral (e.g. 291. Herpes zoster, 380. Measles, 571. Rubella, 668. Varicella, 277. Hand foot and mouth disease)
- 533. Psoriasis

Not so common, though not to miss

- 220. Erythema ab igne
- 355. Liver disease (e.g. 129. Cholestasis of pregnancy)
- 387. Meningococcal sepsis
- 531. Pruritic urticarial papules and plaques of pregnancy (PUPPP)
- Secondary 622. syphilis
- 607. Stevens–Johnson syndrome
- Systemic disease (e.g. 59. Autoimmune and connective tissue diseases [systemic lupus erythematosus], 286. Henoch–Schönlein purpura, 476. Pemphigus)
- 657. Uraemia

Key considerations

- Cholestasis of pregnancy is associated with increased fetal morbidity and mortality
- Consider public health risk from infectious conditions (e.g. contact tracing, exclusion from school or work, mandatory reporting)
- Manage itching to reduce the risk of spread or secondary infection
- Pemphigus is rare but potentially life-threatening
- Review patient's prescribed and over-the-counter medication

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people living in remote areas are at high risk of skin infections and associated complications (e.g. rheumatic fever from impetigo) caused by Group A *Streptococcus*
- Depictions of many skin conditions are of people with fair skin, and therefore the appearance may differ on people with darker skin
- Occupational exposure to chemicals or latex (e.g. hairdressers, cleaners, mechanics)
- Overcrowding is a significant risk factor for some skin conditions
- Some skin conditions are more prevalent in people who live in or visit tropical areas

See also

- [Skin lesions >](#)
- [Skin wounds, injuries and ulcers >](#)

90. Skin wounds, injuries and ulcers

Overview

A break in the integumentary system carries the risk of superimposed infection, further injury, delayed healing and loss of fluid. Most blisters and skin ulcers are minor and self-limiting. However, those associated with systemic disease are more likely to be chronic.

Indicative causes

Common

- 19. Allergic reaction
- Bites and stings
- Chronic venous insufficiency or 680. Venous stasis
- 163. Decubitus ulcers
- 318. Infection (bacterial, viral, fungal)
- 591. Skin cancers
- 649. Trauma

Not so common, though not to miss

- Autoimmune disorders (e.g. 320. Inflammatory bowel disease)
- 71. Behçet disease
- Compulsive skin picking or other 175. Dermatitis artefacta
- 377. Marjolin ulcer in chronic wounds
- 420. Neuropathic ulcers (e.g. 180. Diabetes mellitus, 17. Alcohol use)
- Primary 622. Syphilis
- Ulcers from 43. Arterial insufficiency
- 678. Vasculitides

Key considerations

- Chronic venous ulcers have significant effects on patient wellbeing
- Healing is enhanced by treatment of the underlying aetiology and use of dressings specific to the cause, site and stage of healing
- Some people may be ashamed of skin lesions and therefore may keep them from view (e.g. lesions from violence or self-harm)
- There may be impaired healing among people with diabetes mellitus and people undergoing local or systemic steroid treatment

Consideration of specific groups

- Depictions of many skin conditions are of people with fair skin, and therefore the appearance may differ in people with darker skin
- People who are immobile are at greater risk of decubitus ulcers and venous stasis
- Overcrowding is a significant risk factor for some skin conditions
- Some skin conditions are more prevalent in people who live in or visit tropical areas

See also

- [Bites and stings >](#)
- [Burns and scalds >](#)
- [Skin lesions >](#)

91. Snoring

Overview

Snoring indicates increased upper airway resistance and pharyngeal collapsibility. It may indicate the presence of obstructive sleep apnoea (OSA). Snoring can also be associated with conditions that narrow the upper airway.

Indicative causes

Common

- 17. Alcohol use and smoking
- 278. Allergy
- 620. Swollen tonsils or adenoids, especially among children
- 189. Drug side effects (e.g. sedatives)
- 427. Obesity or local structural changes (e.g. thick neck, misaligned jaw, throat muscle weakness, nasal obstruction, palate shape)
- 519. Pregnancy
- Sleeping position
- 656. Upper respiratory tract infection

Key considerations

- OSA:
 - is commonly associated with snoring
 - is associated with cardiovascular disease
 - can mimic depression and other mental health issues

Common pitfall

- Trivialising the health impacts of snoring

Consideration of specific groups

- Children with OSA may display usual adult symptoms but sometimes display atypical hyperactive behaviour
- Pregnant women with OSA have worse obstetric and perinatal outcomes

See also

- [Difficulty breathing—wheezing or noisy breathing >](#)
- [Nose problem >](#)

92. Substance misuse and addiction

Overview

Addictions can occur with substances, or with behaviours such as gambling or video gaming. They are associated with underlying brain circuitry changes that manifest as impaired control, repeated relapses and craving. There are often physical, social, financial, relationship, educational or occupational consequences.

Substance use disorders are associated with cognitive, behavioural and physiological symptoms, and continued use of a substance despite significant related problems. Substances include alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants (e.g. amphetamines, cocaine); and tobacco. Withdrawal symptoms may occur, but vary considerably between the different classes of substances.

Gambling and other addictive behaviours activate reward systems similar to drugs and have similar associated behavioural symptoms. For gambling, these include agitation when attempting to cut down, chasing losses, preoccupation with gambling, and lying to conceal the extent of the problem.

Indicative causes

Common

- Family history of 615. substance misuse
- Genetic predisposition
- 189. Drug side effects (e.g. prescribed opioids, sedatives, hypnotics, anxiolytics)

Not so common, though not to miss

- 88. Brain injury can result in impairment of brain inhibitory mechanisms
- Disinhibition due to 375. Mania and hypomania

Key considerations

- Early-onset gambling disorder is associated with poor impulse control and substance misuse
- Medical management may be needed during intoxication or withdrawal
- Physical harm and/or infection can occur from intravenous drug use or from behaviours undertaken to acquire the substance
- There is a significant association with mental illness

Consideration of specific groups

- Adolescents are especially vulnerable to substance misuse, as they have decreased impulse control and ability to assess risk
- Gambling disorder occurs more frequently among people with antisocial personality disorder, depressive disorders and bipolar affective disorder
- Groups who are traditionally under-served by education, health systems and job opportunities are especially vulnerable to substance misuse and addiction
- Individuals with gambling disorder have high rates of suicidal ideation and suicide attempts
- People who experienced childhood abuse and/or neglect
- People with chronic pain
- People with fetal alcohol spectrum disorder
- People with post-traumatic stress disorder, including after military service

See also

- [Abnormal thoughts and perceptions >](#)
- [Anxiety >](#)
- [Mood dysfunction >](#)
- [Self-harm and suicidal behaviour >](#)

93. Sweating

Overview

This refers to excessive (perceived or real) integumentary loss of salt and water, sometimes called hyperhidrosis. There can be considerable variation between individuals in how much they normally sweat. It can overlap with heat intolerance.

Indicative causes

Common

- 318. Infection (bacterial, viral, fungal)
- 388. Menopause
- Non-disease causes (e.g. exercise, 427. Obesity, 609. Stress, warm temperatures, spicy food)
- Pain

Not so common, though not to miss

- 31. Anxiety disorders
- 302. Hyperthyroidism
- 305. Hypoglycaemia
- 364. Lymphoma and 352. Leukaemia
- 189. Drug side effects (e.g. SSRIs [selective serotonin reuptake inhibitors])

Key considerations

- Be aware of the distress that sweating may cause

Consideration of specific groups

- Specific consulting skills are needed if gender-related or sexual health issues (e.g. menopause) are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)

See also

- [Fever >](#)

94. Thirst

Overview

The desire to drink is normally associated with dehydration or after excessive salt ingestion.

Indicative causes

Common

- 165. Dehydration from lack of adequate fluid intake or excessive loss (e.g. due to blood loss, diarrhoea, vomiting)
- 180. Diabetes mellitus
- Dry mouth (e.g. due to 189. Drug side effects, radiotherapy, smoking)
- Exercise
- 189. Drug side effects (e.g. lithium, diuretics)

Not so common, though not to miss

- 206. Electrolyte disturbances (e.g. hypercalcaemia)
- 534. Psychogenic polydipsia
- Arginine vasopressin disorder (179. Diabetes insipidus)

Key considerations

Common pitfall

- Not looking beyond lack of adequate fluid intake as the cause

Consideration of specific groups

- Older people can have reduced thirst, even when dehydrated

See also

- [Dry mouth >](#)
- [Sweating >](#)

95. Tinnitus

Overview

Tinnitus refers to a persistent or intermittent ringing or buzzing noise in one or both ears. The aetiology of tinnitus is often idiopathic. It results from abnormalities within the auditory system. It is often distressing and difficult to treat. It may be associated with sensorineural hearing loss, ear infection, ototoxic medication or vascular causes.

Indicative causes

Common

- Age-related (523. Presbycusis)
- Excess 198. Earwax
- 385. Ménière disease
- 422. Noise-associated hearing loss
- 452. Otitis media
- Sensorineural tinnitus
- Vascular (e.g. carotid bruit, venous hum)

Not so common, though not to miss

- 88. Brain injury
- 189. Drug side effects (e.g. excessive aspirin use, ototoxic drugs)
- Neoplasms (e.g. 9. Acoustic neuroma)

Key considerations

- Determine whether the tinnitus is pulsatile or non-pulsatile and whether it is unilateral or bilateral
- Determine whether tinnitus is related to an ear condition or hearing loss
- Most patients have 'sensorineural' tinnitus attributable to hearing loss at cochlear or cochlear nerve level
- People with hypervigilance due to depression or anxiety may be more aware of normal sensations, such as arterial pulsations
- Tinnitus can have a significant impact on the individual and their daily function

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people have a higher risk of chronic otitis media
- Musicians, builders and miners are at greater risk of noise-associated tinnitus

See also

- [Hearing problem >](#)

96. Toothache

Overview

Most instances of toothache will be dental in origin, but they can be due to referred pain from non-dental causes. The role of the doctor is to identify any non-dental causes or to seek dental advice.

Indicative causes

Common

- 170. Dental caries
- 169. Dental abscess
- 301. Impacted third molar (wisdom tooth)
- 482. Periodontal disease
- 589. Sinusitis
- 625. Teething
- 627. Temporomandibular joint dysfunction or 99. Bruxism

Not so common, though not to miss

- Alveolar osteitis (dry socket)
- 25. Angina
- Fracture or other 649. Trauma
- 441. Oropharyngeal cancer
- 448. Osteonecrosis of jaw or tooth socket
- 652. Trigeminal neuralgia

Key considerations

- Do not treat a dental abscess with antibiotics without dental referral for further management
- Patients with dental problems are best treated symptomatically and by referral to a dentist

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people are traditionally under-served by oral health and dental care
- Bisphosphonate treatment increases the risk of osteonecrosis
- Oropharyngeal cancer is more common in smokers
- People with reduced saliva (e.g. Sjögren syndrome, post-radiotherapy) are at greater risk of caries

See also

- [Mouth or throat problem >](#)

97. Trauma—physical

Overview

Trauma and its management often involves multiple systems, and requires care from several disciplines.

Indicative causes

Common

- Explosions
- Gunshot
- Knife injuries
- Motor vehicle accidents
- Self-inflicted
- Sporting
- Workplace, farm or home injuries

Not so common, though not to miss

- Domestic violence and other abuse
- Passive suicidal activity (e.g. increased risk-taking)
- Suicide attempt (e.g. single motor vehicle accidents)

Key considerations

- Apply the principles of triage
- Apply the principles of primary and secondary survey
- Post-traumatic stress disorder can be a complication
- Some people may be ashamed of some injuries and therefore may keep them from view

See also

- [Domestic violence, abuse and neglect >](#)
- [Fracture or dislocation >](#)
- [Shock >](#)
- [Skin wounds, injuries and ulcers >](#)

98. Trauma—psychological

Overview

Extremely frightening or distressing events can result in psychological injury, which may be short-lived or may be ongoing with chronic symptoms. Such events are either life-threatening or pose a significant threat to a person's physical or psychological wellbeing.

Such trauma may result in symptoms that are:

- behavioural (e.g. avoidance, social withdrawal)
- cognitive (e.g. intrusive thoughts, nightmares, poor concentration, dissociative symptoms)
- emotional (e.g. fear, depressed mood, anger, anxiety)
- physical (e.g. hypervigilance, fatigue).

The response to any trauma varies considerably between individuals. It also varies based on the form of trauma. These include physical trauma (e.g. motor vehicle accidents, natural disasters, war situations); sexual violence; domestic violence; childhood abuse and neglect; and psychological trauma. The impact also varies depending on the relationship between the victim and the perpetrator of trauma, the age of the victim, and whether the trauma was a single event or multiple episodes. Particularly among young children, psychological harm can occur from witnessing trauma to others, especially their parents or other primary caregivers.

Indicative causes

Common

- 12. Acute stress disorder
- 31. Anxiety disorders
- 172. Depression
- 514. Post-traumatic stress disorder (PTSD)

Not so common, though not to miss

- 199. Eating disorder
- 488. Personality disorder
- 615. Substance misuse

Key considerations

- Healthcare professionals may suffer from vicarious trauma with similar symptoms to PTSD after hearing patients' trauma stories
- People who are traumatised often avoid talking about the trauma and may avoid presenting for help

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people
- Asylum seekers and refugees
- First responders and armed forces personnel
- Groups of society exposed to discrimination
- People exposed to intergenerational trauma

See also

- [Domestic violence, abuse and neglect >](#)

99. Unplanned pregnancy

Overview

Some pregnancies are unplanned but wanted, and others are not wanted. Some women in this circumstance will present because they do not wish the pregnancy to continue.

In Australia, state and territory legislation defines the circumstances under which termination is legal.

If the practitioner has an ethical or religious objection to termination of pregnancy, they have a responsibility to arrange appropriate referral to a colleague.

Indicative causes

Common

- 151. Contraception failure
- Fetal abnormalities
- Financial and 552. Relationship problems
- 17. Alcohol use and/or 190. Drug use

Not so common, though not to miss

- Hereditary disorders
- 299. Hyperemesis gravidarum
- Mental health issues
- Rape

Key considerations

Common pitfalls

- Not allowing adequate time for full discussion of the pros and cons of termination of pregnancy or change of mind
- Not referring to another practitioner if there are any ethical or religious objections

Consideration of specific groups

- Although pregnancy is family business in Aboriginal and/or Torres Strait Islander populations, the decision regarding termination and/or contraception most often falls upon the women
- If aspects of the consultation are specific to gender in an Aboriginal and/or Torres Strait Islander person, particular skills around the consultation will be needed, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Older women
- Teenagers

See also

- [Pregnancy >](#)

100. Urinary problem

Overview

Patients with urinary conditions can present with one or any combination of incontinence, enuresis, haematuria, dysuria, urethral discharge, hesitancy and frequency.

Blood in the urine can arise from the upper or lower urinary tract, sometimes as a consequence of a systemic illness or bleeding diathesis. Difficulty passing urine can be worsened by pain, medications, constipation and/or immobility. Urinary incontinence can be related to infection or problems with central neurological control, neurological pathways, trauma, urethral sphincter and/or bladder reflex function. Management of incontinence varies according to its type: stress, urge, overflow and/or fistula.

Indicative causes

Common

- 318. Infection
 - 216. Epididymitis
 - Localised skin infection (e.g. 289. Herpes simplex, 242. Fungal infection [candida])
 - 530. Prostatitis
 - 660. Urethritis (e.g. 586. Sexually transmissible infection)
 - 663. Urinary tract infection
- Inflammatory cystitis
- 189. Drug side effects (e.g. medications with anticholinergic effects)
- Nocturnal enuresis among children
- Obstruction
 - 150. Constipation
 - 494. Phimosis
 - 528. Prostate cancer
 - 529. Prostatic hypertrophy
 - 659. Urethral stricture
- 458. Overactive bladder (detrusor over-activity)
- Prostate surgery
- 519. Pregnancy
- 557. Renal stones
- Spinal or epidural anaesthesia
- 662. Urinary tract cancer

Not so common, though not to miss

- 228. Female genital mutilation
- Polyuria due to 210. Endocrinopathies (e.g. arginine vasopressin disorder [179. Diabetes insipidus], 180. Diabetes mellitus)
- 540. Pyelonephritis
- 556. Renal parenchymal disease (e.g. 262. Glomerulonephritis)
- Spinal or sacral 418. Nerve root disease
- 649. Trauma, 238. Foreign body aspiration or 239. Foreign body trauma

Key considerations

- Continence can be impaired by poor cognition and/or reduced mobility
- Frequency is normal in pregnancy and not always due to infection
- Prostatism, urinary retention, incontinence and haematuria are not diagnoses, but do require further explanation
- Urinary retention can indicate primary genital herpes simplex infection

Common pitfalls

- Assuming that smelly or cloudy urine indicate infection; these are unreliable indicators
- Missing overflow incontinence due to retention
- Missing spurious causes of red urine (e.g. menstrual contamination, beetroot, rifampicin)
- Not considering the functional and social impacts
- Not recognising the significance of daytime wetting among children and adolescents

Consideration of specific groups

- Among children who were previously dry at night, bedwetting can be related to psychological trauma
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- People with diabetes mellitus have a higher risk of urinary tract infection
- Pregnant women have a higher risk of asymptomatic urinary tract infection

See also

- [Genital problem—female >](#)
- [Genital problem—male >](#)
- [Preterm labour >](#)
- [Sexual dysfunction >](#)

101. Vaginal bleeding

Overview

Vaginal bleeding is considered abnormal when it occurs at an unexpected time (before menarche or after menopause) or when it varies from what is usual for the individual in amount and pattern. It can originate from the vagina or uterus.

Indicative causes

Common

- **Gynaecological**
 - Cervical 203. Ectropion
 - 211. Endometriosis
 - 233. Fibroids
 - 255. Genitourinary syndrome of menopause
 - 370. Malignancy (e.g. cervical, endometrial)
 - 475. Pelvic inflammatory disease
 - 586. Sexually transmissible infection
 - 649. Trauma
- **Pregnancy**
 - 202. Ectopic pregnancy
 - 311. Implantation bleeding
 - 394. Miscarriage
 - 497. Placenta previa
 - 498. Placental abruption
 - 649. Trauma

Not so common, though not to miss

- 256. Gestational trophoblastic disease
- 624. Systemic bleeding disorder
- 671. Vasa previa
- 689. Vulval and vaginal cancer

Key considerations

Common pitfall

- Postponing examination and investigation because of the vaginal bleeding

Consideration of specific groups

- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Specific consulting skills are required for people who have undergone gender-affirming surgery or vaginal reconstruction

See also

- [Bruising >](#)
- [Genital problem—female >](#)
- [Pelvic pain >](#)
- [Pregnancy >](#)

102. Vaginal discharge

Overview

Vaginal discharge may be a normal process, or related to underlying disease. It varies in quantity, colour, odour and consistency and in some cases is associated with pruritis.

Indicative causes

Common

- 318. Infection (bacterial, viral, fungal)
- 330. Intrauterine contraceptive device
- 351. Leucorrhoea of pregnancy
- Physiological changes in response to hormonal fluctuations of the menstrual cycle
- 255. Genitourinary syndrome of menopause
- 665. Vaginal pessary

Not so common, though not to miss

- 238. Foreign body aspiration or 239. Foreign body trauma
- 654. Tubal malignancy

Key considerations

- A swab is indicated, particularly if:
 - a sexually transmissible infection is a possibility
 - the abnormal discharge persists without an obvious cause
- Characteristics of the discharge will help determine the cause

Common pitfall

- Not excluding a foreign body

Consideration of specific groups

- Menopausal women
- Pregnant women
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Specific consulting skills are required for people who have undergone gender-affirming surgery or vaginal reconstruction

See also

- [Genital problem—female >](#)
- [Pelvic pain >](#)

103. Voluntary weight loss

Overview

Voluntary weight loss is the result of decreased intake and/or increased energy expenditure, sometimes associated with altered body image.

Eating disorders are common, and include anorexia nervosa, bulimia nervosa, binge-eating disorders and others (e.g. pica).

Indicative causes

Common

- Avoidant/restrictive food intake disorder
- Chronic vigorous exercise
- Dieting
- 199. Eating disorder
- Expectations on elite athletes and performers
- Expectations of others
- 349. Laxative and diuretic misuse
- Obsessional traits in childhood
- 428. Obsessive–compulsive disorder
- Poverty
- Weight-loss surgery

Not so common, though not to miss

- 224. Factitious disorder by proxy (e.g. restrictive diets imposed by others)
- Hunger strikers

Key considerations

- Eating disorders are complex and involve attention to psychological, social and cultural considerations—not just diet and lifestyle
- Nutrient deficiencies need to be identified (e.g. protein, iron, vitamin B12, calcium, iodine, zinc)
- Suicide risk is elevated among people with eating disorders

Consideration of specific groups

- Adolescents are often underweight, often due to social pressures. Being underweight in childhood and adolescence can cause long-term physical health and psychosocial problems.

See also

- [Involuntary weight loss >](#)

104. Vomiting blood

Overview

Blood in the vomitus can arise from any part of the upper gastrointestinal tract. Sometimes the blood has arisen from the upper respiratory tract and has subsequently been swallowed.

Indicative causes

Common

- 189. Drug side effects (e.g. non-steroidal anti-inflammatory drugs [NSAIDs], aspirin)
- 245. Gastritis
- 372. Mallory–Weiss tears
- 434. Oesophageal varices
- 435. Oesophagitis
- 477. Peptic ulcer disease
- Tumours

Not so common, though not to miss

- 38. Aorto-enteric fistula
- 81. Bleeding disorders
- 675. Vascular malformations

Key considerations

Common pitfalls

- Not appreciating the impact of medical comorbidities
- Not recognising the severity of blood loss

Consideration of specific groups

- Chronic liver disease predisposes to both portal hypertension with oesophageal varices and bleeding disorders

See also

- [Indigestion and heartburn >](#)
- [Nausea and vomiting >](#)

105. Weakness—focal and generalised

Overview

Focal weakness usually indicates a neurological problem, whereas generalised weakness can be a manifestation of many systemic illnesses.

Indicative causes

Common

- **Focal**
 - 46. Arthropathy
 - Nerve palsy (e.g. 417. Nerve compression and entrapment or 418. Nerve root disease)
 - 610. Stroke or 117. Cerebral space-occupying lesion
 - 649. Trauma to head or spine
- **Generalised**
 - 17. Alcohol use, 190. Drug use and 189. Drug side effects (e.g. statins, corticosteroids)
 - 22. Anaemia
 - 162. Deconditioning or disuse
 - Endocrine (e.g. 306. Hypothyroidism, 159. Cushing syndrome)
 - Metabolic (e.g. 206. Electrolyte disturbances)
 - 468. Paraneoplastic syndrome

Not so common, though not to miss

- 152. Conversion disorder
- 172. Depression
- Genetic conditions (e.g. 404. Muscular dystrophy)
- 269. Guillain–Barré syndrome
- 318. Infection (e.g. 506. Polio, 361. Lyme disease)
- Inflammatory conditions (e.g. 177. Dermatomyositis, 59. Autoimmune and connective tissue diseases [systemic lupus erythematosus])
- 398. Motor neurone disease
- 407. Myasthenia gravis
- 687. Vitamin D deficiency

Key considerations

- Among older people, weakness can arise from inactivity due to fear of falling

Common pitfall

- Only focusing on one system (e.g. muscular causes)

See also

- [Gait disturbance >](#)
- [Numbness and tingling >](#)

Professional practice topics

There are many generic skills needed by doctors that are not specific to a particular patient presentation. Because of their importance to medical practice, they are examinable. In the professional practice section, we have therefore presented them using a similar format to the presentations.

As with the presentations, the aim for each topic is to provide some Australian context and to highlight common pitfalls faced by doctors.

1. Abnormal test results

Overview

Timely follow-up of test results is a legal imperative, and responsibility rests with the doctor who ordered the investigation. The implications of the result, and contribution to management, should be anticipated before ordering tests.

Key considerations

- At the time an investigation is ordered, the doctor should organise how the patient will be informed of the results
- Consider the need for the presence of a support person at the time of receiving certain results
- Follow-up investigation after an abnormal result should be scheduled into the doctor's recall system and monitored adequately
- Results must be provided in a way that ensures confidentiality
- The circumstances must allow time for discussion and/or dealing with any emotional consequences arising from receiving a test result
- The doctor should be familiar with their employer's policy regarding follow-up arrangements for test results
- Ultimately, it is always the referring doctor's responsibility to ensure that investigations are adequately followed up

Consideration of specific groups

- Consider the need for an Aboriginal and/or Torres Strait Islander health worker for Aboriginal and/or Torres Strait Islander patients, according to patient choice
- Consider the need for interpreters for non-English speaking patients
- Consider whether parents should be present for adolescents

See also

- [Breaking bad news >](#)

Useful resources

- Australian Medical Association. Position statement: patient follow-up, recall and reminder systems. Canberra: AMA, 2013. https://ama.com.au/sites/default/files/documents/position_statement_on_patient_follow_up_recall_and_reminder_systems_2013.pdf (accessed May 2026).
- Bird S. The duty of GPs to follow up patients. *Aust Fam Physician* 2013; 42: 245-247.

2. Advance care directive

Overview

An advance care directive is a legal form for people over the age of 18 years. It is an important part of end-of-life care, formalising the patient's needs, values and preferences for future care. It may include details of a substitute decision maker if required.

Key considerations

- Ideally, an advance care directive will be initiated before it is required, or before the patient becomes unwell and loses capacity to make decisions
- It is important for health professionals to be aware of the existence of an advance care directive and to adhere to it as a legal document
- The states and territories have slightly different formal requirements

See also

- [Conflict of rights of patient with the rights of another person >](#)
- [Cultural implications of life transitions >](#)
- [Dying patient >](#)
- [End-of-life issues, euthanasia and assisted suicide >](#)
- [Organ and tissue donation and transplantation >](#)

Useful resource

- Australian Government Department of Health, Disability and Ageing. Advance care directive. Canberra: Commonwealth of Australia, 2025. <https://www.health.gov.au/topics/palliative-care/planning-your-palliative-care/advance-care-directive> (accessed May 2026).

3. Advocacy

Overview

All doctors have a role in advocacy, and contribute their expertise and influence as they work with communities or patient populations to improve health.

There are different levels of advocacy:

1. Patient—advocating for what is best for the patient
2. Patient populations—recognising the special needs of particular populations, and working to meet those needs and ensure equity of access
3. Systems improvement—contributing to improve the processes of health care
4. Political engagement—contributing to political discourse on issues relevant to human health and wellbeing
5. Societal needs—working in ways to improve a society
6. Global—working in ways to improve a global population

Key considerations

- Advocacy often requires engagement with other healthcare professionals, community agencies, administrators, policymakers, and non-healthcare organisations
- At times, the different levels of advocacy can be in conflict (e.g. advocating for an individual patient can be to the detriment of a patient population)
- Doctors are highly influential as role models, and the impact of their everyday words and actions on patients and colleagues can be powerful

Consideration of specific groups

- Advocacy is particularly relevant in any populations where there are health inequities

See also

- [Equitable access to care >](#)
- [Resource allocation >](#)

Useful resources

- Earnest MA, Wong SL, Federico SG. Perspective: physician advocacy: what is it and how do we do it? *Acad Med* 2010; 85: 63-67.
- Royal College of Physicians and Surgeons of Canada. Health advocate. In: CanMEDS framework. Ottawa: RCPSC, 2015. <https://www.royalcollege.ca/en/standards-and-accreditation/canmeds> (accessed May 2026).

4. Angry or distressed patient

Overview

There are many reasons why patients become angry. Some anger arises from the care they have or have not received, whereas other causes relate to external events unrelated to health care. It may arise when patients feel powerless and excluded from decision making.

Key considerations

- Anger can be exacerbated by alcohol, other drugs, mental illness, or by inadequate acknowledgement of the patient's complaints
- Be alert to verbal and nonverbal cues
- Ensure the safety of self, other health professionals and patients
- It can be counterproductive to redefine anger as just anxiety or irritability
- People from cultures that are different from the doctor's can sometimes be misread as angry when they may, for example, be expressing grief, frustration or concern. A doctor should check if any of their own implicit biases may be manifest.

See also

- [Implicit bias and racism >](#)
- [Improving patient safety by speaking up >](#)
- [Open disclosure, dealing with errors, adverse events and complaints >](#)
- [Recognising limitations and calling for help >](#)

Useful resource

- Sim MG, Wain T, Khong E. Aggressive behaviour – prevention and management in the general practice environment. *Aust Fam Physician* 2011; 40: 866-872.

5. Boundaries

Overview

Professional boundaries consist of rules and limits that are specific to a particular professional role (e.g. as a doctor), and which differ from the rules and limits that might apply outside that role (e.g. as a member of the public). For example, any action or behaviour in a doctor–patient relationship that personally benefits the doctor at the expense of the patient is a boundary violation. Within the medical system, boundary issues can affect patient care, patient safety, and the personal lives of doctors and others. Boundary issues can occur between:

- doctors and patients
- doctors and other health professionals
- doctors and other staff
- doctors within the hierarchy.

It is important to be up to date with contemporary guidelines on boundaries.

Key considerations

- Adhere to current expectations on use of chaperones
- Observe mandatory reporting requirements on boundary violations of others
- Practices that are acceptable in some countries may be breaches of boundaries in Australia

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander communities may have strict cultural protocols, which will require special attention
- Boundary expectations may vary according to culture and religion
- Professional advice and peer support should particularly be sought in situations where boundary issues are more challenging (e.g. rural areas and smaller communities)
- The role of family and support systems varies by culture

See also

- [Conflict of interest >](#)
- [Doctors as patients, ‘corridor consultations’ and treating family members >](#)
- [Gifts and inducements >](#)

Useful resources

- Bird S. Managing professional boundaries. *Aust Fam Physician* 2013; 42: 666-668.
- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

6. Breaking bad news

Overview

Conveying serious or bad news should be part of a process, not a one-off event. Openness, tact and empathy are essential. The perception of what is and is not bad news may differ between the patient and doctor. Appropriate ways to discuss bad news will vary by culture. While often applicable to life-threatening illness, the principles are the same for more minor issues. All doctors will have to convey serious or bad news at some stage in their career.

There is no single best way to do this, but there are many models that can be used, such as the SPIKES (set up, perception, invitation, knowledge, empathy, strategy and summary) model [1].

Key considerations

- Ensure key steps are undertaken:
 1. Decide who is the best person to convey the information—this task is preferably undertaken by the most skilled person in the team, who is often the most experienced, but this person may not know the patient best
 2. Set up the situation—attention to timing, privacy, presence of support people, family and/or interpreters
 3. Respect patient requests for confidentiality
 4. Identify and respond to individual cultural and spiritual beliefs
 5. Check prior understanding
 6. Provide information clearly, specifically and honestly
 7. Check that what is conveyed is what is heard; some information may need to be conveyed more than once
 8. Plan for next steps, follow-up, clarification of concerns and additional questions
 9. Prepare for, and deal with, patient and family emotions
 10. Look after yourself—prepare to deal with your own emotions, and seek opportunities to debrief or obtain feedback
 11. Take opportunities to learn from more experienced practitioners
- The role of family and support systems varies between cultures
- Within the Australian context, the patient (or their legal guardian) should be the first person to receive information from their healthcare team. Managing requests for withholding information or provision of information to others can present difficulties, for which advice should be sought. Preferences about who should be told what and by whom can vary by culture.

Common pitfalls

- Being too blunt with no preamble
- Conveying inappropriate certainty about the facts or prognosis
- Not accurately recording the content of the 'bad news' interview in the medical records
- Not appreciating the value of denial as a psychological defence in absorbing bad news
- Not being empathetic
- Overburdening the recipient with too much information
- Providing information before being clear about what is already understood or what the person wants to know
- Using euphemisms or non-specific language

See also

- [Open disclosure, dealing with errors, adverse events and complaints >](#)

Reference

1. Medical Defence Union. Breaking bad news. London: MDU, 2025.
<https://www.themdu.com/guidance-and-advice/guides/breaking-bad-news>
(accessed May 2026).

7. Carer fatigue

Overview

The burden of caring for an unwell relative or friend can become overwhelming for carers, and some may be reluctant to admit that they are struggling. Carers can struggle to balance a sense of duty with meeting their own needs. Doctors should be alert to carer fatigue or to the carer neglecting their own health.

Key considerations

- Be alert to the risk of abuse to the carer or by the carer
- The doctor may need to encourage the carer to attend to their own health
- The doctor should be aware of formal and informal respite and support services
- The ethical dilemma of meeting the competing needs of both parties often requires careful negotiation

Consideration of specific groups

- Expectations of carers may vary according to culture
- Children and adolescents, who may become carers by default, have needs particular to their own health and development

See also

- [Advocacy >](#)
- [Domestic violence, abuse and neglect >](#)
- [Functional decline or impairment >](#)
- [Social aspects of health care >](#)

Useful resource

- Carers NSW Australia. Looking after yourself. <https://www.carersnsw.org.au/services-and-support/advice-for-carers/looking-after-you> (accessed May 2026).

8. Certification

Overview

Doctors have the authority to sign a variety of documents, such as death certificates and sickness certificates. According to the Medical Board of Australia, good medical practice involves:

- 10.9.1 Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate.
- 10.9.2 Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately.
- 10.9.3 Preparing or signing documents and reports if you have agreed to do so, within a reasonable and justifiable timeframe.
- 10.9.4 Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence [1].

Key considerations

- Medical certificates and reports are legal documents
- Never backdate a document

Common pitfalls

- Assuming Indigenous Australian status can be inferred by physical appearance or geographical location
- Documenting someone as non-Indigenous when they have not been asked their Indigenous Australian status
- Not including Indigenous Australian status on relevant documentation
- Leaving questions unanswered

See also

- [Coroner and cause of death certification >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

Useful resource

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.

9. Charter of healthcare rights

Overview

The Australian Charter of Healthcare Rights describes what people can expect when receiving health care, and its principles ‘apply to all people in all places where health care is provided in Australia’ [1].

The principles include an expectation for:

- ability to comment on the care received; patient advocates may be of assistance in the public system
- communication about the available options, costs and treatment and the right to decline treatment
- equity of access to health care for all—this does not mean that all people will have equal access, but that those with more challenging circumstances are able to access health care that is of equal quality and safety
- participation in shared decision making and collaborative care with an accompanying person if necessary
- privacy and confidentiality
- respect for cultural and personal differences
- safe and high-quality care in the community, health services and hospitals.

Key considerations

- Organisational structures can sometimes make it difficult for doctors to uphold the Australian Charter of Healthcare Rights
- Advocacy for safe and quality care is part of a doctor’s role and measures should be taken to improve care if it is seen to be lacking

Consideration of specific groups

- Equity of access is more difficult in rural and remote areas and for patients from disadvantaged groups
- These rights may not legally apply to asylum seekers or foreign visitors who do not hold appropriate insurance

See also

- [Advocacy >](#)
- [Privacy and confidentiality >](#)
- [Improving patient safety by speaking up >](#)

Reference

1. Australian Commission on Safety and Quality in Health Care. Australian charter of healthcare rights, 2nd ed. Sydney: ACSQHC, 2021.
<https://www.safetyandquality.gov.au/resources/australian-charter-healthcare-rights-second-edition-all-translations> (accessed May 2026).

10. Conflict of interest

Overview

A conflict of interest exists when a doctor's capacity to act in the best interests of patients is compromised by 'relationships with other people, groups, or businesses' [1]. Bias in judgement or actions may be conscious or unconscious [1]. A conflict of interest occurs when an action benefits the doctor but may be detrimental to the patient.

Areas where conflicts of interest are likely to occur include:

- coercion of a patient to be used for teaching medical students
- financial or business activities where financial gain could be to the detriment of the patient
- ownership of nursing homes or diagnostic facilities
- pharmaceutical and other industries where recommendation of interventions provides financial or other benefits to the prescribing doctor
- prioritising self-care or family over patient care
- recruitment into research projects
- sporting teams, the military, family, religious groups, community groups, and occupational groups where decisions for the benefit of the group could be to the detriment of the patient

The Australian Medical Association suggests that conflicts of interest could be managed by:

- withdrawing from a particular decision;
- withdrawing from or curtailing involvement in a particular activity;
- divesting of financial interests;
- delegating functions or roles to another individual or group [2].

Key considerations

- Be aware of pressure from groups to which you belong
- Consider self-reflection and discussion with others to identify and deal with conflicting priorities
- If in doubt, declare the potential conflict of interest and seek advice
- Unconscious priorities and conflicts of interest may affect medical practice

See also

- [Boundaries >](#)
- [Doctors as patients, 'corridor consultations' and treating family members >](#)
- [Research ethics >](#)

References

1. Muth CC. Conflict of interest in medicine. *JAMA* 2017; 317: 1812.
2. Australian Medical Association. Guidelines for doctors on managing conflicts of interest in medicine 2018. Canberra: AMA, 2018. <https://ama.com.au/position-statement/guidelines-doctors-managing-conflicts-interest-medicine-2018> (accessed May 2026).

Useful resources

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

11. Conflict of rights of patient with the rights of another person

Overview

The doctor–patient relationship should be based on mutual respect, trust and confidence. A competent patient has the right to choose their doctor and to accept or decline any recommended investigation or treatment.

When a person has an impaired ability to make decisions (e.g. cognitive deficit, psychosis), another person may take on that role. Often this is done informally by a partner or family member helping a person with a mental incapacity to make decisions about their finances, living circumstances, health or self-care.

However, when there are disagreements between family members about making decisions for the person with mental incapacity or there is conflict with the patient themselves, then formal arrangements are needed. Such arrangements are made through an appropriate statutory authority and involve a formal pathway of assessing competence and appointing a guardian to make important decisions.

Another situation that raises particular ethical issues occurs in maternal–fetal conflict: when a pregnant woman’s interests conflict with the interests of the fetus. This might include:

- life choices (e.g. smoking, drinking alcohol, taking drugs, exposure to hazards) that can harm the fetus
- the mother declining health recommendations (e.g. blood transfusions, surgical procedures, caesarean section) that can benefit the fetus.

Generally, the mother’s autonomy and rights should be respected in decision making. A good doctor–patient relationship can create an environment where the doctor can provide information in a non-judgemental way, thereby helping the mother make the best decision. Rarely, legal intervention may be necessary as the final arbitrator, such as when both maternal and fetal life is at risk if the recommended treatment is refused.

Key considerations

- The concept of a doctor withholding information from a patient on the grounds that, in the doctor’s opinion, this protects the patient is now regarded as paternalistic. Such behaviour does not respect patient autonomy or their right to choose treatment.
- When involuntary psychiatric treatment occurs under the criteria of mental health legislation, the patient continues to have patient rights (e.g. to be provided with information about rights of appeal, access to legal representation, access to family or friends, rights to a second opinion)

Consideration of specific groups

- Children
- Expectations of carers vary according to culture
- People with cognitive impairment or psychosis
- Pregnant women

See also

- [Advance care directive >](#)
- [Involuntary treatment or treatment without consent >](#)
- [Patient-centred care >](#)
- [Refusal of treatment >](#)
- [Resource allocation >](#)

12. Consent

Overview

Before proceeding with any investigation, treatment or sharing of information, the doctor must obtain informed consent from the patient, provided they have capacity. The person performing the procedure is responsible for discussing, obtaining and documenting consent.

Generally, the law requires that the patient be able to understand and retain treatment information, believe the information, weigh the information and reach a decision, and communicate his or her decision [1].

Written and oral communication should be in a form that can be understood by the patient. If the patient and doctor do not share a common language, an accredited interpreter should be used. Informed consent should be tailored to the patient's understanding to take into account individual circumstances.

Medical students seeing patients must always be identified as such, and consent obtained, preferably by someone other than the student.

Key considerations

- Consent may be withdrawn at any time
- Consent can take several forms depending on circumstance:
 - major or experimental interventions—the consent must be in writing, dated, signed by the patient and stored in the patient record
 - minor interventions—a written record of oral consent may be sufficient
 - when consent is implied, a written record may not be needed, but verbal confirmation of consent is still essential
- Continued consent may need to be confirmed or updated
- Expectations around the degree of documentation vary according to context and procedure; doctors should comply with state/territory and institutional guidelines

Consideration of specific groups

- Children
- Detained refugees
- Involuntarily admitted patients under a state or territory Mental Health Act
- Organ donors
- People having body tissue or biopsy material stored (e.g. for research)
- People undergoing electroconvulsive therapy
- People undergoing genetic testing

- People who lack capacity who have a legal guardian or power of attorney
- People who lack capacity who do not have a legal guardian or power of attorney
- People with impaired consciousness
- Prisoners

Some groups and situations require special considerations in order to obtain informed consent. If in doubt, it is best to contact your medical indemnity organisation or the public advocate.

See also

- [Genetic testing and DNA sovereignty >](#)
- [Interpreters >](#)
- [Organ and tissue donation and transplantation >](#)
- [Research ethics >](#)

Reference

1. Snow HA, Fleming BR. Consent, capacity and the right to say no. *Med J Aust* 2014; 201:486-488.

Useful resources

- Bird S. Capacity to consent to treatment. *Aust Fam Physician* 2011; 40: 249-250.
- Bird S. Consent to medical treatment: the mature minor. *Aust Fam Physician* 2011; 40: 159-160.
- Office of the Public Advocate. Patient capacity to consent. Melbourne: State of Victoria, 2021. <https://www.publicadvocate.vic.gov.au/medical-treatment/patient-consent/patient-capacity-to-consent> (accessed May 2026).

13. Continuing professional development

Overview

Continuing professional development is essential to ensure all doctors remain competent and up to date. It is often a mandatory requirement for ongoing registration and credentialing. Self-assessment alone is insufficient to determine gaps in performance. Learning that is not driven by performance data is more likely to be directed towards existing strengths and interests. Learning activities are more effective when based on audit, peer review, critical incident reviews, feedback and other quality assurance activities. Identification of learning needs should be relevant to a doctor's casemix and scope of practice.

Key considerations

- Continuing professional development can include activities that occur during regular work (e.g. checking drug interactions, teaching, discussions with colleagues) and more structured activities (e.g. completing online learning activities, attending conferences, grand rounds, journal clubs, audit meetings, courses)
- Learning activities are more effective when related to learning needs and when they are supported by independent, high-quality sources of information (e.g. practice guidelines, systematic reviews) and use active modes of learning
- Learning needs should be drawn from a person's scope of practice and from data on actual performance
- Over-reliance on self-assessments will be insufficient to identify all learning needs

Consideration of specific groups

- Solo practitioners, or those working in professional isolation, are more at risk of not recognising their deficits and of making medical errors

See also

- [Duty of care >](#)
- [Supervising others and teaching >](#)

Useful resource

- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

14. Coroner and cause of death certification

Overview

Doctors are required to complete death certificates for patients who die while under their care. Death certificates are legal documents and must be completed promptly and accurately by an appropriately registered doctor. Incorrect completion could have implications for the validity of the will, life insurance or compensation. Statistics from death certificates are collected for mortality registers that influence public health and community interventions and research.

The coroner should be notified if the doctor is not 'comfortably satisfied' as to the cause of death. If the doctor is unsure about completing the certificate, they should contact their supervising doctor, the coroner or their medical indemnity organisation to discuss.

Key considerations

- Death certificate requirements vary between states and territories
- Doctors may be asked to sign a death certificate after certifying the death of a patient they have not seen before. If there is adequate documentation of illnesses that are likely to have been responsible for the death, the doctor should document these as the cause of death on behalf of the patient's usual doctor.
- In many cultures, there are rituals and cultural rules associated with death. The doctor may need to consult family and cultural leaders in order to respect these as much as possible.
- It is important to determine whether the doctor is authorised to complete a death certificate
- 'Reportable deaths' are when the coroner must be notified if:
 - a doctor has been unable to sign a death certificate giving the cause of death
 - the identity of the person who has died is not known
 - the person died during or as a result of a medical procedure
 - the person died in a violent or unnatural manner
 - the person died unexpectedly and the cause of death is unknown
 - the person was held in care or in custody immediately before they died (noting that 'in care' excludes facilities such as residential aged care)
 - where the death resulted, directly or indirectly, from an accident or injury, even if there has been a prolonged interval between the incident and death [1]
- There are separate documents for neonates under 28 days of age

Common pitfalls

- Assuming Indigenous Australian status can be inferred by physical appearance or geographical location
- Documenting someone as non-Indigenous when they have not been asked their Indigenous Australian status
- Not including Indigenous Australian status on relevant documentation
- Leaving questions unanswered

See also

- [Certification >](#)
- [Dying patient >](#)

Reference

1. Australian Bureau of Statistics. Cause of death certification guide. Canberra: ABS, 2024 [latest update]. <https://www.abs.gov.au/statistics/detailed-methodology-information/cause-death-certification-guide/australia> (accessed May 2026).

Useful resource

- Bird S. How to complete a death certificate – a guide for GPs. *Aust Fam Physician* 2011; 40: 446-449.

15. Critical interpretation of data

Overview

Clinicians need to be able to assimilate data from many sources, including patient history, physical findings and investigations, as well as published data and articles, conference presentations and guidelines, particularly for the purpose of evidence-based patient care.

Key considerations

- Doctors need to:
 - interpret reviews and analyses from published research, including recognising the hierarchy of evidence
 - understand basic statistical principles and be able to interpret information appropriately
 - understand the basic principles of research design
- Doctors should be able to explain any deviation from current clinical and therapeutic guidelines
- Doctors should select and interpret investigations and management based on utility, sensitivity, specificity and cost, appropriate to the individual patient
- Doctors should understand the rationale for screening programs, including costs, benefits and adverse impacts
- Doctors should understand the sensitivity and specificity of screening tests in order to interpret results and decide next steps
- Use of evidence and the application of guidelines requires consideration of context, patient factors and resources

See also

- [Abnormal test results >](#)
- [Research ethics >](#)

16. Cultural implications of life transitions

Overview

Times such as birth and parenthood, transition to adulthood, marriage, leaving and returning home, retirement, onset of disability, end-of-life care and death of others often carry significant cultural implications and associated expected norms. Likewise, there can be important norms associated with body part donation, use of genetic material and touching of body parts. Such events require conversations about cultural expectations and values.

Key considerations

- Aboriginal and/or Torres Strait Islander health workers, cultural advisers and religious advisers can be helpful, but be mindful of not making assumptions about what a person would wish
- Ideally, the patient's views should be known before these transitions but if in doubt, always ask

See also

- [Advocacy >](#)
- [Determinants of health \(see \[Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines\]\(#\)\) >](#)
- [Equitable access to care >](#)
- [Historical and intergenerational trauma >](#)
- [Implicit bias and racism >](#)
- [Organ and tissue donation and transplantation >](#)
- [Patient-centred care >](#)

17. Cultural safety terminology and definitions

Overview

Australia has an ancient Indigenous history, and a more recent history of immigration of peoples from a wide variety of cultures, backgrounds and nationalities. Doctors in any area will interact with people from various cultural backgrounds, and need to understand the implications for culturally appropriate care for their patients.

There is national and international evidence of health inequities among peoples who are marginalised and under-served. Such inequities are particularly prevalent among Aboriginal and Torres Strait Islander people. There is also evidence that health practitioners and institutions contribute to these inequities by making stereotypical assumptions about people who are different from them. Health practitioners are often part of the majority population, or, even if they come from different cultures, they usually work in systems that are designed by the majority population.

There are a range of overlapping and sometimes conflicting definitions and terminology, including cultural competency and cultural safety. The meaning of culture in this context relates to the 'normal' or 'usual' way things are done.

The Australian Health Practitioner Regulation Agency defines culturally safe practice as 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism' [1]. Doctors should understand the definitions and wordings used by the relevant regulatory bodies and local employers appropriate for them.

Doctors must be prepared to critique the 'taken for granted' power structures and challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others. The objective of cultural safety activities must be clearly linked to achieving health equity.

Key considerations

- Cultural norms can also perpetuate power relationships
- The practice of medicine has its own culture, which can also inadvertently be seen as the norm

Common pitfall

- Assuming that one has no culture of their own, which can lead to the assumption that one's views, values and ways of looking at the world are the norm

See also

- [Advocacy >](#)
- [Determinants of health \(see Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines\) >](#)
- [Equitable access to care >](#)
- [Historical and intergenerational trauma >](#)
- [Implicit bias and racism >](#)
- [Culture of medicine in Australia >](#)

Reference

1. Australian Health Practitioner Regulation Agency. National scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025. Canberra: Ahpra, 2020. <https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx> (accessed May 2026).

Useful resource

- Curtis E, Jones R, Tipene-Leach D, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019; 18: 174.

18. Departing and returning travellers

Overview

The responsibilities of travellers to protect their health and the health of others will vary according to the countries visited and those countries' current risks and regulations.

Departing travellers

Vaccinations, medications and advice should be based on the countries and areas being visited, the type of trip (e.g. cruise, adventure, self-drive, diving, altitude), type of accommodation, and the patient's age, gender and overall health.

Ensure that patients are aware of Smartraveller, an Australian Government Department of Foreign Affairs and Trade website. Smartraveller provides country-specific information about safety, health, local laws, travel, insurance and local contacts, and offers crisis support for Australians overseas [1].

Returning travellers

There are some useful questions that can help assess a patient who has returned from a trip:

1. Where have they been?
2. When did they return?
3. What did they do?
4. Did they access medical services overseas?
5. Did they take all their medications and follow all advice (e.g. water purification, mosquito protection, use of condoms)?
6. Were they exposed to any high-risk situations (e.g. bites by dogs or monkeys, uncooked meat)?

Key considerations

- Be particularly aware of patients who are visiting their country of birth to see friends and family. Their immunity to local endemic illnesses may have waned (e.g. typhoid, malaria) and they may need vaccinations or medication to be protected.
- Consider whether any disease acquired overseas needs to be notified to public health authorities; such notifiable diseases vary by state and territory

Common pitfall

- Failure to take a comprehensive travel history and/or not being aware of prevalent infectious diseases in the visited country

Consideration of specific groups

- People who are immunocompromised are at risk of infections that are more easily acquired during travel
- People who are taking medications may need supporting documentation to allow them to carry prescribed drugs and devices
- Pregnant women should check gestational age-specific travel restrictions and avoid travel to areas where they may be at risk

See also

- [Fever >](#)

Reference

1. Smartraveller. Travel advice explained. Canberra: Australian Government Department of Foreign Affairs and Trade, 2025 [latest update]. <https://www.smartraveller.gov.au/consular-services/travel-advice-explained> (accessed May 2026).

Useful resource

- Australian Technical Advisory Group on Immunisation. Australian immunisation handbook. Canberra: Australian Government Department of Health, 2018. <https://immunisationhandbook.health.gov.au> (accessed May 2026).

19. Disease outbreak

Overview

Widespread outbreaks of infectious diseases have always been a feature of human civilisation, with socioeconomic impacts beyond health. Outbreaks can be local, regional, national or global. Epidemics such as new influenza strains or coronaviruses can evolve rapidly into pandemics due to increased global mobility. Infectious gastroenteritis outbreaks are common in hospitals, childcare facilities, aged-care institutions or where people share accommodation. Hospital-acquired pneumonia or colitis due to *Clostridioides difficile* are common causes of hospital-based infectious outbreaks.

Key considerations

- Containment, isolation and contact tracing are often necessary
- Control measures will depend on the mode of spread
- Ethical considerations are raised around individual rights versus social or communal benefits
- Interventions often require public health strategies to control or avoid overwhelming health services and/or resource rationing
- Particular care needs to be given to protect first responders and health workers and their families
- Physical distancing and personal hygiene, particularly use of masks and handwashing, can be very effective
- Testing, where available, is essential
- Where available, immunisation should be used to protect individuals and the population (e.g. measles)

Consideration of specific groups

- Health workers and first responders
- Older people with comorbidities and people who are immunocompromised are at higher risk of contracting infectious diseases, and of more severe illness
- People in crowded or confined areas (e.g. sporting events, cruise ships, residential care, prisons)

See also

- [Immunisations >](#)

Useful resource

- World Health Organization. Disease outbreaks. Geneva: WHO. <https://www.who.int/teams/environment-climate-change-and-health/emergencies/disease-outbreaks> (accessed May 2026).

20. Doctor shopping

Overview

‘Doctor shopping’ refers to a pattern of behaviour wherein a person consults several different doctors of the same or similar discipline for the same purpose. This can be to obtain a treatment, medical diagnosis or opinion that agrees with the views of the patient.

The goal is often to obtain prescription medication, particularly a drug of dependence, with the intention of misuse, self-harm or sale. The patient consults multiple doctors assuming that the newly consulted doctor will be unaware that another doctor has already prescribed, or refused to prescribe, the same or similar type of drug.

Key considerations

- Doctors may be easily persuaded by patients, with or without drug addiction, with plausible stories and/or documentation
- Drugs commonly requested by doctor shoppers include fentanyl patches, oxycodone, tramadol and benzodiazepines
- Presenting complaints are often pain related without physical signs (e.g. migraine, recurrent pancreatitis, back pain, renal colic) or plausible reasons why simple analgesics are ineffective
- Software (e.g. SafeScript) enables real-time prescription monitoring throughout Australia

Consideration of specific groups

- People taking opioid substitution therapies

See also

- [Medication review and prescribing >](#)

Useful resources

- Avant Learning Centre. Identifying drug seekers and doctor-shopping behaviours. Sydney: Avant Mutual, 2023. <https://avant.org.au/resources/identifying-drug-seekers-and-doctor-shopping-behaviours> (accessed May 2026).
- Choahan N. Doctor shopping and what it means for GPs. *NewsGP* 2018; 23 Aug. <https://www1.racgp.org.au/newsgp/professional/doctor-shopping-and-what-it-means-for-gps> (accessed May 2026).
- Services Australia. Prescription shopping programme. Canberra: Commonwealth of Australia, 2024 [latest update]. <https://www.servicesaustralia.gov.au/prescription-shopping-program> (accessed May 2026).

21. Doctors as patients, ‘corridor consultations’ and treating family members

Overview

Doctors as patients are at greater risk of adverse events due to the temptation to self-diagnose and self-treat. Not having one’s own general practitioner is particularly risky. There is a high risk of suboptimal care (e.g. misdiagnosis, inadequate management, limited follow-up, lack of privacy) when prescribing or ordering tests is undertaken without adequate consultation or without a formal doctor–patient relationship. This is more likely to occur in brief (‘corridor’) consultations with work colleagues. Similar issues can occur when treating family members or close friends.

Doctors can find it difficult to be a patient and seek health care. Barriers can include embarrassment, loss of control, fear of mandatory reporting, and lack of confidentiality, privacy and/or time. Doctors can also feel uncomfortable treating other doctors and may treat them differently, including untested assumptions of the doctor–patient’s prior medical knowledge.

Doctors have an increased risk of psychological distress, burnout, relationship breakdown, self-harm and suicide.

Key considerations

- Attend to patient education and ensure adequate follow-up
- Be aware of the health system or public risks in not detecting and/or acting on an impairment or illness in a colleague, particularly those that require mandatory reporting
- Consultations where the patient is a doctor can be uncomfortable or awkward for both parties, but the consultation should be managed as for other patients
- Difficult areas of conversation may be inappropriately avoided when consulting or treating colleagues or family members
- It is inadvisable for doctors to diagnose and treat themselves, family members or close friends
- The law on self-prescription varies depending on the type of drug and between states and territories

See also

- [Boundaries >](#)
- [Conflict of interest >](#)
- [Recognising limitations and calling for help >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Useful resources

- Doctors' Health Alliance. <https://doctorshealthalliance.org.au/> (accessed May 2026).
- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Drs4Drs. <https://www.drs4drs.com.au> (accessed May 2026).
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

22. Domestic violence, abuse and neglect

Overview

Abuse is never acceptable. It can take several forms, including physical, emotional, sexual and financial. Neglect is also a form of abuse. Physical injury and abuse may be referred to as non-accidental injury.

Family, domestic and sexual violence occurs across all age, socioeconomic and demographic groups, but mainly affects women and children. Aboriginal and/or Torres Strait Islander women, young women, people with disabilities and pregnant women are particularly at risk. Intimate partner violence causes more illness, disability and death than any other risk factor for women aged 25–44 years. Older people are also at increased risk.

The effects of domestic violence are psychological, emotional and physical, and it affects social, interpersonal and financial domains.

Key considerations

- Criminal justice system and health service providers may contribute to the trauma by disbelief, minimising responses and victim blaming
- Disclosure requires development of trust, which may take time
- Ensuring the safety of the victim is paramount
- Financial abuse may take some time to emerge
- Resilience and recovery are promoted by positive reactions of support and strong social networks
- Sensitive exploration of the issues and support often requires expert and multidisciplinary intervention
- Under-reporting is common; people will not report abuse unless they feel protected and in a safe and non-judgemental environment
- Victims may initially defend their abuser
- Warning signs of abuse may include:
 - anxiety, depression or non-specific physical symptoms
 - concealing injuries
 - deterioration in school or work performance
 - inconsistent and/or evasive history
 - repeated or non-specific presentations
 - unexplained bruises and/or injuries
 - unexplained sudden deterioration of the health or functioning of a person in institutional care
- Witnesses, especially children, can also be traumatised

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander women are much more likely than other women to be hospitalised or die due to family violence
- Abuse is a leading cause of homelessness for women with children
- Abuse, or even suspicion of abuse, of children requires mandatory reporting; details vary by jurisdiction [1]
- LGBTQI (lesbian, gay, bisexual, transgender, queer and intersex) people are at particular risk of under-reporting, under-recognition and inadequate assistance following domestic violence
- Separation of family members from each other can have particular impact on Aboriginal and/or Torres Strait Islander people

See also

- [Carer fatigue >](#)
- [Fracture or dislocation >](#)
- [Historical and intergenerational trauma >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)
- [Trauma—physical >](#)
- [Trauma—psychological >](#)

Reference

1. Australian Institute of Family Studies. Mandatory reporting of child abuse and neglect. Canberra: Commonwealth of Australia, 2026. <https://aifs.gov.au/resources/resource-sheets/mandatory-reporting-child-abuse-and-neglect> (accessed May 2026).

Useful resources

- Royal Australian College of General Practitioners. Abuse and violence – working with our patients in general practice. White book, 5th ed. Melbourne: RACGP, 2021. <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble> (accessed May 2026).
- World Health Organization. Social determinants of health: violence prevention. Geneva: WHO. <https://www.who.int/teams/social-determinants-of-health/violence-prevention> (accessed May 2026).

23. Duty of care

Overview

Duty of care is a legal obligation. The doctor–patient relationship carries with it a duty to make the care of the patient a doctor’s priority and to practise safely and effectively. Once such a relationship arises, the doctor is required to attend to the patient with continuity, and to exercise reasonable care, skill and judgement until the relationship is ended through an appropriate process.

Key considerations

- A relationship is deemed to have formed once a referral has been accepted, even though the patient may not yet have been seen
- Doctors must ensure they are fit to practise, including when on call, and not permit any physical or psychological impairment to interfere with care of their patients
- Duty of care extends beyond the consultation to include the effects of treatment or advice after the consultation
- The clinician must ensure there is adequate follow-up, handover and/or transfer

See also

- [Advocacy >](#)
- [Continuing professional development >](#)
- [‘Good Samaritan’ and rendering assistance >](#)
- [Handover and referral >](#)
- [Recognising limitations and calling for help >](#)
- [Resource allocation >](#)

Useful resources

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

24. End-of-life issues, euthanasia and assisted suicide

Overview

Caring for patients who are ill and coming to the end of their life is an important role for doctors. The responsibilities are enunciated clearly by the Medical Board of Australia in its code of conduct:

Doctors have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients towards the end of their life, good medical practice involves:

4.13.1 Taking steps to manage a patient's symptoms and concerns in a manner consistent with their values and wishes.

4.13.2 Providing or arranging appropriate palliative care, including a multi-disciplinary approach whenever possible.

4.13.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

4.13.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

4.13.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

4.13.6 Respecting different cultural practices related to death and dying.

4.13.7 Striving to communicate effectively with patients and their families so they are able to understand the outcomes that can and cannot be achieved.

4.13.8 Encouraging advance care planning and facilitating the appropriate documentation, such as an advance care directive (or similar).

4.13.9 Taking reasonable steps to ensure that support is provided to patients and their families, even when it is not possible to deliver the outcome they seek.

4.13.10 Communicating bad news to patients and their families in the most appropriate way and providing support for them while they deal with this information.

4.13.11 When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

4.13.12 Sensitively discussing and encouraging organ and tissue donation with the patient's family, when appropriate and consistent with legislation and accepted protocols [1].

Key considerations

- An assessment should be made about whether treatment is futile or burdensome, noting that:
 - doctors are not legally obliged to provide futile treatment
 - patients have no legal right to insist on treatment that doctors believe is futile
- Caring for a person at the end of their life should not just be about stopping treatment—it requires active management of symptoms, emotions and attending to carers and relatives
- Confidentiality applies even after a patient's death, which can be particularly relevant when communicating to others the cause of death
- Euthanasia laws vary by state and territory, and doctors are not expected to make such decisions in isolation
- Norms and expectations for end of life vary by culture
- Withholding or withdrawing treatment can be a difficult decision, and should be made in consultation with the patient, family and significant other parties

See also

- [Advance care directive >](#)
- [Cultural implications of life transitions >](#)
- [Dying patient >](#)
- [Organ and tissue donation and transplantation >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

25. Equitable access to care

Overview

Access to health care, and timely progression through the health system, should be available equally for all Australians, but this is not the case. Healthcare providers, including doctors, contribute to this inequity, and have an obligation to apply even greater effort to promote access to care for people who are adversely affected.

Key considerations

- Access to care can be enhanced by effectively engaging with relevant community services, community members and other health workers (e.g. Elders, community leaders, Aboriginal and/or Torres Strait Islander health workers, church groups, community transport services)
- Auditing one's practice against common demographic parameters can reveal unrecognised inequities
- Doctors should address barriers to equitable access to care that are specific to their patients as well as systemic factors

Common pitfall

- Assuming that treating all people the same will remove inequity

Consideration of specific groups

- Any person who differs from the treating doctor (e.g. in culture, nationality, gender, sexual orientation) is at greater risk of being treated inequitably

See also

- [Advocacy >](#)
- [Establishing Indigenous Australian status >](#)
- [Implicit bias and racism >](#)

Useful resources

- Australian Institute of Health and Welfare. Australia's health. Canberra: AIHW. <https://www.aihw.gov.au/reports-data/australias-health> (accessed May 2026).
- Diaz A, Whop LJ, Valery PC, et al. Cancer outcomes for Aboriginal and Torres Strait Islander Australians in rural and remote areas. *Aust J Rural Health* 2015; 23: 4-18.
- Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, Stith AY, Nelson AR, eds. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press (US), 2003.
- Titmuss A, Davis EA, Brown A, Maple-Brown LJ. Emerging diabetes and metabolic conditions among Aboriginal and Torres Strait Islander young people. *Med J Aust* 2019; 210: 111-113.e1.

26. Establishing Indigenous Australian status

Overview

Establishing Indigenous Australian status is important for helping doctors offer culturally appropriate and good clinical care. There are more than 350 different groups of people Indigenous to Australia, who are described in two broad groups—Aboriginal people and Torres Strait Islander people. Establishing Indigenous Australian status can open up more targeted and clinically appropriate pathways of care. It also aids accurate data collection from which inequities can be addressed and problems can be made more visible.

The Australian Government definition of an Aboriginal and/or Torres Strait Islander person is someone who:

1. is of Aboriginal and/or Torres Strait Islander descent, and
2. self-identifies as Aboriginal and/or Torres Strait Islander, and
3. is accepted as such by the community in which they live and work.

Key considerations

- Ask all patients if they are an Aboriginal and/or Torres Strait Islander person, so this becomes routine, normalised and embedded in practice
- Doctors need to be confident and competent when asking patients if they identify as an Aboriginal and/or Torres Strait Islander person, and to explain why this information is needed
- It is not the doctor's role to decide whether someone is an Aboriginal and/or Torres Strait Islander person

Common pitfalls

- Assuming Indigenous Australian status can be inferred by physical appearance or geographical location
- Documenting someone as non-Indigenous when they have not been asked their Indigenous Australian status
- Not including Indigenous Australian status on relevant documentation

See also

- [Advocacy >](#)
- [Equitable access to care >](#)
- [Implicit bias and racism >](#)

Useful resources

- Australian Institute of Health and Welfare. Fact sheet: 'Are you of Aboriginal or Torres Strait Islander Origin?' Canberra: AIHW, 2025 [v16.0]. <https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/indigenous-identification> (accessed May 2026).
- Royal Australian College of General Practitioners, National Faculty of Aboriginal and Torres Strait Islander Health. Identification of Aboriginal and Torres Strait Islander people in Australian general practice [position statement]. Melbourne: RACGP, 2020. <https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health/policy-and-advocacy/position-statements/identification-of-aboriginal-and-torres-strait-isl> (accessed May 2026).
- Services Australia. Indigenous Access Program. Canberra: Commonwealth of Australia, 2022 [latest update]. <https://www.servicesaustralia.gov.au/indigenous-access-program> (accessed May 2026).

27. Extended family and community relationships

Overview

Patients have a variety of preferences on how much they wish their health status to be shared with others. Much of this is culturally determined. Some may wish families to know about their health, whereas others will want to preserve their privacy. The level of support from the extended family can be an important determinant of health.

Some Aboriginal and/or Torres Strait Islander peoples have complex family and community relationship structures and nomenclatures—for example, sister, cousin, uncle and aunty are terms that can have different meanings in different contexts. There is a long history of traditional adoption practices across Australia that result in strong family connections.

Key considerations

- Be aware of the use and meaning of terms such as:
 - carer
 - guardian
 - next of kin (which may not always be one person)
 - power of attorney

Common pitfalls

- Assuming that family requests to withhold information from the patient should be accepted
- Making assumptions about who in the family or community, if anyone, should be informed or involved in care decisions

See also

- [Advance care directive >](#)
- [Consent >](#)
- [Determinants of health \(see \[Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines\]\(#\)\) >](#)
- [Historical and intergenerational trauma >](#)
- [Privacy and confidentiality >](#)

28. Gender diversity, intersex and transgender identities

Overview

Gender diversity is an umbrella term for nonconformity to societal or cultural expectations for the gender a person was assigned at birth. Cisgender people are aligned with the gender they were assigned at birth, whereas transgender people experience a mismatch between their gender identity and their assigned gender. Gender dysphoria or gender incongruence describes the distress experienced by a person due to a difference between their gender identity and their sex assigned at birth. Many transgender people's genders are binary (i.e. male or female). Non-binary genders fall between or outside the binary, including agender (having no gender) or genderfluid (varying over time) identities. Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. Intersex people can be cisgender or transgender. Doctors need to be aware of, and sensitive to, an individual's gender identity and how they wish to be treated.

Social transition consists of the steps many transgender people choose to take to alter their presentation in the world to better align with their gender identity. Social transition may involve:

- changing hairstyle, using makeup or wearing gender-affirming clothing
- using a gender-affirming name and pronouns (e.g. he/him, she/her, they/them)
- wearing undergarments to alter body shape (e.g. chest binders to achieve a more masculine chest appearance; packers to simulate the appearance of male genitals through clothing; padded bras to create a more feminine chest appearance).

Medical and surgical transition involve hormonal treatments (e.g. estrogen, progesterone, testosterone) and gender-affirming surgeries (e.g. breast implants, mastectomy, genital surgery).

Key considerations

- Consider whether a full history of transition is required for the presenting problem, and whether male or female reference ranges are more appropriate for the circumstance
- Enquire about and use preferred name and pronouns
- Gender dysphoria can be accompanied by other mental health conditions (e.g. anxiety, depression, self-harm, suicide)
- Recognise that each individual is the expert on their own gender
- The person's family may need support to understand gender diversity

- Transgender young people need to be assessed routinely for risks of abuse, bullying, drug and alcohol use, nutrition and unhealthy eating behaviours, sexual health and mental health concerns

Common pitfalls

- Assuming that medical and mental health conditions are related to the person's transgender status or gender-affirming treatments when they are more likely unrelated ('trans broken arm' syndrome)
- Making assumptions about what medical or surgical gender-affirming treatments the person is taking or has undergone

Consideration of specific groups

- Neurodiversity (autism spectrum disorder) is common among the transgender community
- Specific consulting skills are needed if gender-related or sexual health issues are being considered for an Aboriginal and/or Torres Strait Islander person, as outlined in [Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines](#)
- Stigma can be greater within some cultural groups, whereas others have different conceptualisation of gender (e.g. 'third gender' cultures)

Useful resources

- Lyons A. Transgender health: journey to care. *Good Practice* 2017; 4: 14-16.
- Royal Australasian College of Physicians. RACP statement on gender dysphoria. Sydney: RACP, 2020; 6 Mar. <https://www.racp.edu.au/news-and-events/media-releases/racp-statement-on-gender-dysphoria> (accessed May 2026).
- TransHub. Information for clinicians. <https://www.transhub.org.au/clinicians> (accessed May 2026).

29. Genetic testing and DNA sovereignty

Overview

Genetic testing (including prenatal or pre-implantation genetic diagnosis), personalised medicine, pharmacogenomics, organ donation, tissue banks and linked datasets are increasing parts of medical practice.

Genetic material reflects one's ancestry and genealogy, and is passed on to future generations. Genetic information may also inform treatment options. Genetic testing has implications beyond the individual patient, including for ancestors, descendants and siblings.

Views on how genetic material should be handled will be influenced by cultural expectations and values. There may be a tension between individual and collective rights and responsibilities.

Key considerations

- Counselling is needed prior to and after genetic testing, and should include implications for:
 - family planning
 - pregnancy
 - travel, life and health insurance
 - unexpected findings
- Doctors should seek the views of patients, and understand relevant community norms and relevant legislation prior to collecting any material
- Intergenerational impacts can be significant because the information obtained pertains to others beyond the contributor of the genetic material
- Sensitivity is needed regarding storage and disposal of blood samples, tissue samples and/or genetic information, particularly in research
- Specialist genetic counselling should be considered

Consideration of specific groups

- Particular sensitivity is needed when dealing with genetic material and data from Aboriginal and/or Torres Strait Islander people
- Pregnant women
- Women undergoing assisted reproductive technology treatment

See also

- Abnormal test results >
- Consent >
- Organ and tissue donation and transplantation >
- Privacy and confidentiality >
- Well person check and screening >

Useful resources

- World Health Organization. Genomics. <https://www.who.int/health-topics/genomics> (accessed May 2026).
- Zhong A, Darren B, Loiseau B, et al. Ethical, social, and cultural issues related to clinical genetic testing and counseling in low- and middle-income countries: a systematic review. *Genet Med* 2021; 23: 2270-2280.

30. Gifts and inducements

Overview

Gifts intended to influence practising behaviour or that create a conflict of interest are not acceptable. Bribes are never acceptable.

Key considerations

- Business arrangements with patients can influence, or can be perceived to influence, practice
- Health departments, practices and hospitals often have local guidelines or policies
- Loans or bequests from patients to their doctors should be discouraged, but could be deferred to an institution or research body
- Receiving gifts is particularly problematic where commercial interests are involved, as there is a risk that there is an expectation of a reciprocal service from the doctor
- Small gifts from patients may be acceptable, provided they do not influence or cannot be perceived to influence practice

See also

- [Boundaries >](#)
- [Conflict of interest >](#)

Useful resources

- American Medical Association Council on Ethical and Judicial Affairs. AMA code of medical ethics' opinions on physicians' relationships with drug companies and duty to assist in containing drug costs. *Virtual Mentor* 2014; 16: 261-264.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

31. 'Good Samaritan' and rendering assistance

Overview

'Good Samaritan' refers to situations where a doctor is outside their usual clinical practice environment and comes across an urgent situation where their medical expertise would be useful to preserve life or limit injury. Examples include a person who collapses on the street, a doctor encounters a motor vehicle accident, or there is a call for a doctor on an aeroplane.

Nearly all Australian states and territories have in place good Samaritan legislation to ensure that people who step forward to provide emergency medical assistance are not held legally liable for their actions provided they act in good faith [1].

Key considerations

- Doctors should recognise their own scope of practice, but should not let this prevent them helping if there is no-one more qualified. There may be other bystanders so the doctor should determine the relevant skill sets available.
- Initial interventions should be followed by a plan for handover or ongoing care
- The doctor should always ensure their own safety
- The doctor should be fit to assist (e.g. not be under the influence of alcohol)
- This does not apply to non-urgent matters where there is opportunity for an appropriately qualified person to intervene

See also

- [Boundaries >](#)
- [Duty of care >](#)

Reference

1. Eburn M. Good Samaritan legislation and scope of practice. *Aust Emerg Law* 2015; 27 Mar. <https://emergencylaw.wordpress.com/2015/03/27/good-samaritan-legislation-and-scope-of-practice/> (accessed May 2026).

Useful resources

- Australian and New Zealand Committee on Resuscitation. Guidance statement 10.5.1 – legal issues related to responding to emergency situations and resuscitation. 2025. <https://www.anzcor.org/home/education-and-implementation/anzcor-guidance-statement-10-5-1-legal-issues-related-to-responding-to-emergency-situations-and-resuscitation> (accessed May 2026).
- Smith M. What is my duty to assist in an emergency? *MJA Insight* 2017; 9 Oct. <https://www.doctorportal.com.au/mjainsight/2017/39/what-is-my-duty-to-assist-in-emergency/> (accessed May 2026).

32. Handover and referral

Overview

Referral involves sending a patient to obtain an opinion or treatment from another doctor or healthcare professional. Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside an area of expertise. Handover is the process of transferring all responsibility to another healthcare professional. Handover includes hospital discharge summaries.

The Medical Board of Australia advises that good medical practice involves:

6.3.2 Taking reasonable steps to ensure that the person to whom you delegate, refer or handover has the qualifications, experience, knowledge and skills to provide the care required.

6.3.4 Always communicating sufficient information about the patient and the treatment they need to enable the continuing care of the patient [1].

It is important to ensure that clinical handover is concise, precise, and provides all relevant facts, to safely transfer critical information. An example of a structure to use is ISBAR (Identify, Situation, Background, Assessment, Recommendation).

Referrals should similarly contain facts relevant to the patient's situation that convey enough information to ensure continuity of care.

Key considerations

- Even when care is referred to another health professional, ongoing reciprocal communication between both parties is essential
- Referrals and handover (including discharge summaries) should always be timely
- The referring doctor cannot transfer responsibility for the pertinent component of the patient's care until the referral has been accepted
- The referring doctor should ensure that it is clear to the patient, family and colleagues who has ultimate responsibility for coordinating the care of the patient
- There are Medicare requirements as to who can refer; to whom they can refer; who can be referred; for what period of time; and what information needs to be part of the referral

See also

- [Establishing Indigenous Australian status >](#)
- [Interprofessional collaboration >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

Useful resource

- Australian Government Department of Health, Disability and Ageing. Medicare Benefits Schedule. Note GN.6.16. In: MBS online. Canberra: Commonwealth of Australia, 2020. <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.6.16&qt=noteID> (accessed May 2026).

33. Historical and intergenerational trauma

Overview

Intergenerational trauma refers to psychological or physically damaging experiences transmitted across generations. Examples include children of survivors of disaster, war and genocide, such as the Holocaust, the Vietnam War and its aftermath; children of the Stolen Generations (the forced removal of Aboriginal and Torres Strait Islander children from their families); and those who are only now learning of their Indigenous ancestry. Such events can affect that child's development, subsequent parenting practice, mental health and/or interactions with the health system. As well as trauma from one generation to the next, there can also be longer-term historical trauma against a group of people, such as genocide, banning a language, forced relocation or desecration of monuments. The effects of such trauma are far-reaching and can persist.

Key considerations

- Ignorance of, or insensitivity to, a patient's history or historical events can mask important factors affecting a patient's presentation. This also risks re-traumatising these people or exacerbating pre-existing trauma.
- People from marginalised groups are at risk of under-diagnosis, under-treatment or stigma

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people
- Asylum seekers and refugees and their descendants
- Survivors of childhood abuse

See also

- [Domestic violence, abuse and neglect >](#)
- [Implicit bias and racism >](#)

Useful resources

- Atkinson J. Trauma-informed services and trauma-specific care for Indigenous Australian children. Resource sheet no. 21. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies, 2013. <https://www.aihw.gov.au/reports/indigenous-australians/trauma-informed-services-and-trauma-specific-care/summary> (accessed May 2026).
- Australians Together. The Stolen Generations: the forcible removal of First Nations children from their families. Adelaide: Australians Together, 2020. <https://australianstogether.org.au/discover-and-learn/our-history/stolen-generations> (accessed May 2026).
- Kezelman C. Trauma informed practice. Canberra: Mental Health Australia, 2014; 12 Jun. <https://www.mentalhealthaustralia.org.au/articles/news/trauma-informed-practice/> (accessed May 2026).
- Royal Australian College of General Practitioners. Abuse and violence: working with our patients in general practice. White book 5th ed. Melbourne: RACGP, 2022. <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble> (accessed May 2026).

34. Immunisations

Overview

The *Australian immunisation handbook* provides clinical guidelines for healthcare professionals and others about the safest and most effective use of vaccines in their practice [1]. The guidelines are evidence-based and continually updated.

There is a federally funded childhood immunisation schedule with expectations for adherence (e.g. access to childcare). There are also government-funded immunisation schedules for specific groups (e.g. refugees, Aboriginal and/or Torres Strait Islander people, older people). These schedules may differ between states.

Despite the proven community benefits of immunisations, there are groups within society who are actively opposed to vaccinations.

Key considerations

- Differentiate active from passive immunisation and live (attenuated) from inactivated vaccines
- If the doctor cannot confirm official documentation of previous vaccinations, they should proceed to vaccinate according to Australian guidelines
- Immunisation is not only for the benefit of the individual, but also through herd immunity, which benefits other members of the community, especially the vulnerable
- It is the responsibility of the medical practitioner to record the vaccination in the Australian Immunisation Register [2], especially for children
- Pre-vaccination screening—including questions about medications, pregnancy and allergies—is very important, especially for live vaccines
- Some vaccinations have particular contraindications or cautions (e.g. yellow fever)
- The schedule for boosters and follow-up is dependent on the individual's specific characteristics such as age, comorbidities, health status and pregnancy
- The World Health Organization provides information on overseas vaccination schedules and country-specific requirements for vaccines [3]

Common pitfalls

- Not checking the requirements for government-funded free vaccines
- Not checking medication or allergy history, especially immune-modulating drugs
- Not considering vaccination in a situation where it would be required (e.g. penetrating injury, risks associated with unborn children)
- Not making appropriate arrangements for follow-up vaccinations

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people
- Anti-vaccination ('anti-vaxxer') groups
- Children
- Occupational risk (e.g. healthcare workers, farmers, childcare workers)
- Overseas travellers
- People who are immunocompromised
- Pregnant women
- Refugees

See also

- [Well baby check >](#)
- [Well person check and screening >](#)

References

1. Australian Technical Advisory Group on Immunisation. Australian immunisation handbook. Canberra: Australian Government Department of Health, Disability and Ageing. <https://immunisationhandbook.health.gov.au> (accessed May 2026).
2. Australian Government Services Australia. Australian Immunisation Register. Canberra: Commonwealth of Australia, 2025 [latest update]. <https://www.servicesaustralia.gov.au/australian-immunisation-register> (accessed May 2026).
3. World Health Organization. Immunization, vaccines and biologicals. Geneva: WHO, 2020. <https://www.who.int/teams/immunization-vaccines-and-biologicals> (accessed May 2026).

35. Implicit bias and racism

Overview

Implicit bias, sometimes referred to as unconscious bias, refers to decisions being made based on prior experience, personal deep-seated thought patterns, stereotypical assumptions or interpretations. By definition, people are unaware of these powerful influences on decision making. Implicit bias is common in medical practice and can result in suboptimal outcomes.

Racism can be defined as organised systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups.

Implicit bias and racism shape the way in which the determinants of health are distributed within society, and how health services are funded, distributed and delivered.

Key considerations

- Although racism is often interpersonal, the more prevalent manifestation is institutional racism (e.g. institutional policies that ignore cultural values and norms; the number of family members allowed at a hospital bedside; policies on headwear that ignore the needs of a multicultural community)
- Appreciation of social diversity and understanding of historical injustices can help avoid stereotyping
- Because people are unaware of implicit bias, periodic audits or reviews of decision making must be undertaken to uncover and deal with unrecognised actions that disadvantage particular patient groups
- Bias is more likely to be activated in demanding situations (e.g. time constraints, multitasking, pressure to make a diagnosis or treatment decision, stress, fatigue, sleep deprivation)
- People tend to have the most positive bias towards people with whom they share characteristics (e.g. age, sexuality, ethnicity, gender, religion)
- Racism is perpetuated by people who consider themselves non-racist
- Self-reflection is insufficient to identify biases; there are steps that can be taken to help identify implicit biases and intervene accordingly

Common pitfall

- Assuming that clinical practice is objective and free from bias

Consideration of specific groups

- People who are different from the treating doctor are at greater risk of being stereotyped

See also

- Advocacy >
- Determinants of health (see Aboriginal and/or Torres Strait Islander health workers and the use of Indigenous medicines) >
- Equitable access to care >
- Historical and intergenerational trauma >
- Interpreters >

Useful resources

- Australian Human Rights Commission. There's nothing casual about racism. Canberra: AHRC, 2025. <https://humanrights.gov.au/our-work/campaigns/race/theres-nothing-casual-about-racism> (accessed May 2026).
- Australian Indigenous Doctors' Association. Racism in Australia's health system [policy statement]. Canberra: AIDA, 2018. https://aida.org.au/app/uploads/2021/01/Racism-in-Australias-health-system-AIDA-policy-statement_v1.pdf (accessed May 2026).
- Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. *J Exp Soc Psychol* 2012; 48: 1267-1278.
- Project Implicit. Implicit association test. Project Implicit: 2011. <https://implicit.harvard.edu/implicit/takeatest.html> (accessed May 2026).
- United Nations. Fight racism. <https://www.un.org/en/fight-racism> (accessed May 2026).

36. Improving patient safety by speaking up

Overview

Speaking up, also known as ‘whistleblowing’, is when doctors raise concerns about patient safety and care quality after recognising or becoming aware of the risky or deficient actions of others. Concerns about patient safety are the responsibility of all health professionals, with the objective of achieving better health outcomes. In the first instance, concerns might be raised with the person or the team. In some circumstances, a more systemic approach is needed.

Safety concerns that require speaking up include:

- conflicts of interest
- diagnostic and medication errors
- disregarding hygiene, sterility and safety protocols
- impaired colleague
- unprofessional behaviour
- unsafe work practices.

Often, health professionals hesitate to voice concerns. Factors that hinder speaking up include:

- concerns about impact on future career
- cultural influences
- fear of being ostracised in the workplace
- hierarchies within health care
- lack of knowledge of reporting pathways or workplace support.

Key considerations

- Ask for advice from a trusted senior colleague, a union representative or a medical defence organisation
- Check institutional policy before communicating directly with the media
- Consider whether there is a requirement to report an impaired colleague to the Australian Health Practitioner Regulation Agency
- Incidents that jeopardise patient safety should be managed according to organisational policies

See also

- Advocacy >
- Open disclosure, dealing with errors, adverse events and complaints >
- Privacy and confidentiality >
- Record keeping, medicolegal issues and mandatory reporting >
- Supervising others and teaching >

Useful resource

- Australian Health Practitioner Regulation Agency. Making a mandatory notification. Canberra: Ahpra, 2020. <https://www.ahpra.gov.au/Notifications/Raise-a-concern/Mandatory-notifications.aspx> (accessed May 2026).

37. Interprofessional collaboration

Overview

Most doctors work closely with a wide range of healthcare professionals. Patient care is improved when there is mutual respect and clear communication between professionals, as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's disciplines. Working in a team does not alter a doctor's personal accountability for professional conduct and the care provided.

Doctors should know their own and other's limits and recognise the system hierarchy, lines of authority and reporting requirements.

The Medical Board of Australia advises that good medical practice involves:

5.2.1 Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient.

5.2.2 Communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient.

5.2.3 Behaving professionally and courteously to colleagues and other practitioners including when using social media.

5.3.1 Understanding your particular role as part of the team and fulfilling the responsibilities associated with that role [1].

Key considerations

- Communication with colleagues must ensure confidentiality—particularly when digital or social media are used
- Respect colleagues who have different skill sets, experience or views
- Work culture should ensure differences of opinion are able to be shared and resolved

See also

- [Handover and referral >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

38. Interpreters

Overview

The role of an interpreter is to facilitate communication between people who do not use the same language. People who do not have English as their first language are at greater risk of health inequities due to misdiagnosis and inappropriate treatment. This includes those who use a sign language as their first language; in the Australian context the most common sign language is Auslan.

Unless it is a life-threatening emergency, family members should not act as interpreters due to problems with confidentiality and the risk of introduction of interpersonal biases that can affect free exchange of information and informed decision making.

Key considerations

- Bilingual staff, unless appropriately accredited, should not be presumed to have the necessary skills to act as interpreters
- Interpreters are also available for people who are hard of hearing, deaf or part of the Deaf community
- Patients who use English well may still prefer to use an interpreter when discussing medical issues

See also

- [Cultural implications of life transitions >](#)
- [Implicit bias and racism >](#)
- [Patient-centred care >](#)

Useful resources

- Australian Government Department of Home Affairs. Translating and Interpreting Service (TIS National). <https://www.tisnational.gov.au/> (accessed May 2026).
- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).
- Phillips C. Using interpreters – a guide for GPs. *Aust Fam Physician* 2010; 39: 188-195.

39. Involuntary treatment or treatment without consent

Overview

People with mental illnesses who are at risk of harming themselves or other people can be detained under specific sections of a state or territory Mental Health Act by an ‘authorised person’, including doctors. This has led to the colloquial term ‘sectioning’.

Involuntary treatment refers to people with mental disorders or illnesses admitted to hospital after being detained (‘sectioned’) or receiving community treatment orders under the applicable Mental Health Act after a Mental Health Review Tribunal hearing.

Treatment without consent refers to compulsory (typically physical) treatment approved under a Guardianship Order.

There are several circumstances when such treatment will be considered. Jurisdictions will differ on the exact legislation covering these circumstances, and doctors should be familiar with the relevant legislation.

In deciding when to provide treatment without consent, one criterion is the ‘best interests test’, which requires a balancing of the benefit to the patient against the risks of the proposed treatment. Another criterion is the ‘substituted judgement test’, which involves making a decision consistent with what the person would have decided if they had the capacity to do so.

Key considerations

- A decision to treat without consent should be made with at least one other medical colleague
- Comprehensive documentation explaining the rationale for any decision should always be completed
- In an emergency situation when the patient is unconscious, semiconscious, delirious or otherwise unable to give informed consent, the next of kin should initially be contacted. If this is not possible, the ‘best interests test’ should be applied.
- In rare circumstances when life is at risk (e.g. refusing blood transfusion in late pregnancy with haemorrhage and possibility of both maternal and fetal death), legal measures may need to be taken
- People with no capacity to give informed consent (e.g. intellectual disability, child, dementia) will usually have a legal guardian or substitute decision maker who can make the decision on their behalf
- Solo practitioners, especially in rural and remote settings, may feel less supported to make decisions about treating without consent. They should seek support from legal entities and colleagues.

See also

- Abnormal thoughts and perceptions >
- Conflict of rights of patient with the rights of another person >
- Refusal of treatment >

Useful resource

- Australian Law Reform Commission. Informed consent to medical treatment. Canberra: ALRC, 2014. <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/10-review-of-state-and-territory-legislation/informed-consent-to-medical-treatment/> (accessed May 2026).

40. Medication review and prescribing

Overview

Periodic review of medications is necessary to ensure that patients are prescribed evidence-based treatment that is effective, minimises interactions with other medications, and does not cause unnecessary side effects.

In Australia, some medications can be bought without a prescription ('over the counter'), some can only be prescribed on a private prescription (non-subsidised), and some are subsidised by the Australian Government Pharmaceutical Benefits Scheme (PBS). Some medications can only be prescribed by particular specialists or after health department authorisation. Medicines (and poisons) are classified into schedules according to the level of regulatory control over the availability of the medicine or poison required to protect public health and safety.

Some medications may only be prescribed using the PBS if they meet the restrictions specified in the prescribing schedule. These restrictions may indicate use for only specific diseases, in certain population groups, or after positive pathological diagnosis. If medications do not meet these requirements they can often be prescribed on a private prescription, although they are not subsidised.

The categorisation system and database for prescribing medications in pregnancy and breastfeeding have been developed based on available evidence of risks.

Key considerations

- Ensure adherence to professional guidelines when treating patients experiencing substance misuse and/or dependence
- It is important to ask about non-prescription and complementary medications, as they may have side effects or interact with prescribed medicine
- Prescribers must understand the rules governing use of drugs of dependence (Schedule 8) and the dangers of prolonged use of these medications
- Seek out and communicate with any others who are prescribing medication for the patient
- Some jurisdictions have computerised programs that allow communication of prescribing and dispensing records for certain high-risk medicines to be transmitted between doctors and pharmacists
- There should always be regular monitoring and review of medication

Consideration of specific groups

- Prescribing of narcotics and self-prescribing (and for family) laws are different in each state and territory
- Take care with people who are pregnant, breastfeeding or planning to conceive

See also

- [Doctor shopping >](#)
- [Handover and referral >](#)
- [Telehealth >](#)

Useful resources

- Australian Breastfeeding Association. Breastfeeding and medicines. Melbourne: ABA, 2023. <https://www.breastfeeding.asn.au/resources/breastfeeding-and-medicines> (accessed May 2026).
- Hotham N, Hotham E. Drugs in breastfeeding. *Aust Prescr* 2015; 38: 156-159.
- Pharmaceutical Benefits Scheme. Prescribing medicines – information for PBS prescribers. Canberra: Australian Government Department of Health, Disability and Ageing, 2025 [latest update]. http://www.pbs.gov.au/info/healthpro/explanatory-notes/section1/Section_1_2_Explanatory_Notes (accessed May 2026).
- Therapeutic Goods Administration. Prescribing medicines in pregnancy database. Canberra: Australian Government Department of Health, Disability and Ageing, 2025 [latest update]. <https://www.tga.gov.au/products/medicines/find-information-about-medicine/prescribing-medicines-pregnancy-database> (accessed May 2026).
- Therapeutic Goods Administration. Scheduling basics of medicines and chemicals in Australia. Canberra: Australian Government Department of Health, Disability and Ageing, 2023 [latest update]. <https://www.tga.gov.au/how-we-regulate/ingredients-and-scheduling-medicines-and-chemicals/scheduling-basics-medicines-and-chemicals-australia> (accessed May 2026).

41. Motivational interviewing, lifestyle advice and brief interventions

Overview

Motivational interviewing is a non-confrontational person-centred counselling strategy aimed at resolving ambivalence and increasing a person's motivation to change, by discussing change without attempting to convince the person of the need to change or instructing them about how to change. It is often used as a therapeutic tool for cessation of smoking, alcohol and other drug use, and problem gambling, as well as in areas such as diabetes mellitus and weight management.

Motivational interviewing involves:

- encouraging the patient to consider benefits and compare potential outcomes if they do make changes versus if they do not
- helping the patient determine specific and achievable solutions to the challenges
- helping the patient identify areas for change
- helping the patient identify challenges and barriers involved
- highlighting discrepancies between present behaviour and broader goals
- reflective and empathetic listening.

As with motivational interviewing, lifestyle advice should be tailored to the individual and their context and the patient should be a collaborative partner in the development of any management plan.

Key considerations

- Brief interventions are based on motivational interviewing and problem-solving techniques and often comprise opportunistic counselling and information on certain types of harms and risks associated with drug use and/or risky behaviours (e.g. opportunistic motivational interviewing may be arranged following a routine health check such as blood pressure medication prescription or immunisation)
- Motivational interviewing is an important intervention for drug and alcohol addiction

See also

- [Well person check and screening >](#)

Useful resource

- Hall K, Gibbie T, Lubman DI. Motivational interviewing techniques – facilitating behaviour change in the general practice setting. *Aust Fam Physician* 2012; 41: 660-667. <https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques> (accessed May 2026).

42. Open disclosure, dealing with errors, adverse events and complaints

Overview

Acting immediately to rectify the problem, if possible, is an essential component of dealing with any error or adverse event. The doctor must comply with relevant policies, procedures and reporting requirements (including to the Australian Health Practitioner Regulation Agency), in consultation with their medical indemnity insurer.

Open disclosure is a two-way process for ensuring that open, honest, empathetic and timely discussions occur between patients and/or their support people and health service staff following a patient safety incident. It may require more than one meeting.

The elements of open disclosure are:

1. An apology or expression of regret, acknowledging patient distress and providing appropriate support
2. A factual explanation of what happened
3. An opportunity for the patient, the family and their support persons to relate their experience
4. A discussion of the potential short-term and long-term consequences of the adverse event
5. An explanation of the steps being taken to manage the adverse event and prevent recurrence.

In all circumstances, the doctor should ensure that patients have access to a patient advocate and the process for making a complaint.

Key considerations

- A doctor may suffer feelings of guilt, shame or loss of confidence after an adverse event
- Dealing with an adverse event in a timely and empathetic manner decreases the patient's or family's need to proceed with a formal complaint
- For their own wellbeing, a doctor may need to access their own support throughout this process
- It is important for the doctor to recognise their own feelings after an error, adverse event or complaint and ensure that they do not compromise open disclosure and ongoing care
- There are several ways to identify and minimise errors following an adverse event (e.g. root-cause analysis)

See also

- [Breaking bad news >](#)
- [Improving patient safety by speaking up >](#)
- [Recognising limitations and calling for help >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Useful resources

- Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework. Sydney: ACSQHC, 2014. <https://www.safetyandquality.gov.au/resources/australian-open-disclosure-framework-better-communication-better-way-care> (accessed May 2026).
- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

43. Organ and tissue donation and transplantation

Overview

Organ transplantation is a highly effective treatment for advanced organ failure that relies on donation from living or deceased people. Organ donation is a process whereby a person allows an organ to be removed, either by consent while the donor is alive or after death with the assent of the next of kin.

Currently, Australia has an opt-in system for organ and tissue donation. It is voluntary and donors receive no payment. There are waiting lists for patients to receive donations.

Organs and tissues that can be donated include: blood, plasma, stem cells, kidneys, heart, lungs, liver, small bowel, pancreas, cornea, heart valves, bones, skin, veins and tendons.

There are some risks to living donors such as surgical complications, failure of the remaining organ (e.g. kidneys, liver) or emotional impact.

Key considerations

- Be alert to coercion on donors from family members or undue social pressure
- Cultural and religious beliefs about organ donation vary, and should be taken into account
- It is important to provide factual information without being coercive about becoming an organ donor or recipient
- Sudden death does not always preclude organ or tissue donation

See also

- [Advance care directive >](#)
- [Cultural implications of life transitions >](#)
- [Dying patient >](#)
- [End-of-life issues, euthanasia and assisted suicide >](#)

Useful resources

- Australian Government Department of Health, Disability and Ageing. Organ and tissue donation. <https://www.health.gov.au/topics/organ-and-tissue-donation> (accessed May 2026).
- Australian Government Organ and Tissue Authority. Donate life. <https://donatelife.gov.au> (accessed May 2026).

44. Patient-centred care

Overview

Views vary about what causes illness and what qualifies as effective treatment and management. Doctors are no different and also hold a variety of views. Doctors and patients may not share the same set of beliefs. A positive therapeutic relationship increases the likelihood of interventions being effective and outcomes improved. Building a therapeutic relationship requires exploring the patient's beliefs and expectations regarding health, wellbeing, illness and their determinants. Doctors should assess the patient's degree of insight, explore their preconceived ideas of their illness (including causes and treatments), and ensure they have been given sufficient information. This forms the foundation of patient-centred care.

Key considerations

- Building an effective therapeutic relationship often requires time and compromise
- Consider appropriate cultural, spiritual and religious beliefs and practices
- Cultural issues can arise around many issues, including food, examining body parts, organ donation, blood products, modesty, menstruation and at times of birth and death
- During patient examination, the doctor should be mindful of the patient's values
- Management plans should take account of social, cultural and lifestyle factors
- Pitfalls can occur when a doctor only works within a biomedical model
- Some people may find it difficult to tell a doctor if they disagree

See also

- [Conflict of rights of patient with the rights of another person >](#)
- [Cultural implications of life transitions >](#)
- [Cultural safety terminology and definitions >](#)
- [Equitable access to care >](#)
- [Interpreters >](#)
- [Involuntary treatment or treatment without consent >](#)
- [Organ and tissue donation and transplantation >](#)
- [Refusal of treatment >](#)

Useful resource

- BetterHealth Channel. Patient-centred care explained. Melbourne: Victorian Government, 2015. <https://www.betterhealth.vic.gov.au/health/servicesandsupport/patient-centred-care-explained> (accessed May 2026).

45. Patient images and photos

Overview

There are some occasions in medical practice when an image or photo can assist best practice, such as:

- diagnostic purposes for second opinion (e.g. retinal images, skin rashes, burns)
- education purposes (e.g. hospital grand rounds, journal articles, small group learning)
- medicolegal (e.g. sexual assault, workers' compensation)
- patient record (e.g. skin, wounds, palsies, burns, retinal photos, video otoscope, X-rays).

It is important that the doctor ensures they have documented patient consent for the photo to be taken and used for the specific purpose outlined. The photo must be deleted from any personal device after it has been saved in the record or sent for diagnostic purposes to the specialist or hospital. All photos used for education purposes must be de-identified.

Consider the security of the transmission services and sites where the images will be sent and stored. The doctor should ensure that the image is either stored in the patient's medical file or deleted after diagnostic services are no longer needed.

Patient images should not be used for advertising purposes.

Key considerations

- If in doubt, seek legal advice through a medical defence organisation
- Images should not be used for purposes other than that for which the patient has given permission
- It is important to have a patient's documented permission to use their image for diagnostic and education purposes

Consideration of specific groups

- Cultural sensitivity (special care needs to be taken if sharing images of Aboriginal and/or Torres Strait Islander people who have died)
- Rural and remote practitioners will often send images to larger centres for diagnostic purposes

See also

- [Handover and referral >](#)
- [Privacy and confidentiality >](#)
- [Telehealth >](#)

Useful resources

- Australian Medical Association, Medical Indemnity Industry Association of Australia. Clinical images and the use of personal mobile devices. Canberra: AMA, 2014. https://www.ama.com.au/sites/default/files/2021-10/FINAL_AMA_Clinical_Images_Guide_0.pdf (accessed May 2026).
- NITV. Indigenous cultural protocols: what the media needs to do when depicting deceased persons. Sydney: NITV, 2017. <https://www.sbs.com.au/nitv/article/indigenous-cultural-protocols-what-the-media-needs-to-do-when-depicting-deceased-persons/97xq2otnt> (accessed May 2026).

46. Privacy and confidentiality

Overview

Patients have the right for their personal and medical information to be confidential. In general, a doctor requires the patient's consent to disclose any information to a third party, including other health providers, family members and employers. Patients also have the right to privacy and to the accuracy of the recording of their personal and biographical information. Patients may access their records. Information is increasingly being sent by electronic communications, and it is essential that any patient information sent electronically must be adequately protected with internet security.

Exceptions to the obligation for confidentiality are when information is required by law or in public interest situations. Examples include:

- notifiable diseases
- reporting births and deaths
- suspected child abuse, domestic abuse or other situations requiring mandatory reporting
- when a doctor suspects a firearm injury, or that a patient with a physical or mental illness has a firearm that is a threat to their own or another person's safety
- when a patient is considered an imminent threat to others
- when a patient with a mental disorder is considered a danger to themselves or others.

Key considerations

- Appropriate sharing of information with other health providers does not normally breach confidentiality and privacy
- Sharing a patient's information with other staff in the hospital when it is not necessary for the patient's treatment breaches confidentiality
- The duty of confidentiality continues after the death of a patient, which then transfers to the executor or administrator of their estate
- The duty of confidentiality extends to non-health professionals who may be privy to a patient's information (e.g. reception staff)

Common pitfall

- Making assumptions around what information can be shared with family without first checking with the patient

See also

- Conflict of rights of patient with the rights of another person >
- Consent >
- Improving patient safety by speaking up >
- Open disclosure, dealing with errors, adverse events and complaints >
- Patient images and photos >
- Record keeping, medicolegal issues and mandatory reporting >
- Telehealth >

Useful resources

- Australian Medical Association. AMA Code of Ethics 2025. Canberra: AMA, 2025. <https://www.ama.com.au/articles/ama-code-ethics-2025> (accessed May 2026).
- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.

47. Recognising limitations and calling for help

Overview

Doctors should not undertake any activity or procedure outside their knowledge and skill set if any appropriately skilled practitioner is available.

In rural and remote settings, access to help may be more difficult and resources will be limited. If the situation is outside the doctor's level of competency, or in an emergency situation, advice can be sought by phone or teleconference. Other health professionals may also have skills that will be of assistance in these situations.

All facets of medicine are evolving, and continuing professional development is essential.

Key considerations

- The patient's wellbeing is paramount

See also

- [Improving patient safety by speaking up >](#)
- [Interprofessional collaboration >](#)
- [Open disclosure, dealing with errors, adverse events and complaints >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Useful resource

- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

48. Record keeping, medicolegal issues and mandatory reporting

Overview

The medical record can be accessed by many people (including the patient), so it needs to be informative, truthful, accurate, objective, timely and stored securely. In some circumstances, and with appropriate permission, the record can also be accessed by others such as lawyers, relatives, researchers and auditors.

A doctor may have contact with the police or the legal system in circumstances such as:

- assessment of fitness to be interviewed by the police or to plead
- assessment of victims of sexual or physical assault, or domestic violence
- conflict of patient confidentiality and knowledge of criminal behaviour
- death or interaction with a coroner
- legal requirements related to involuntary admission or ongoing retention within psychiatric units, according to state and territory Mental Health Acts
- mandatory notification—child abuse, firearms, unsafe health practitioners
- medicolegal reports
- notifiable diseases
- people brought by the police for medical or psychiatric assessment
- subpoenas for medical records and to appear in court
- treatment of a person who is in custody.

A doctor needs to maintain good relationships with the police and judiciary while still discharging their duty of care and ensuring public safety.

Key considerations

- A health record can be used in legal proceedings, insurance claims or disputes (e.g. relationship or testamentary)
- Any attempt to alter a medical record can be seen as falsification unless it is clearly stated when and why that change was made. Falsifying medical records can have serious consequences for the person making those changes.
- Be clear about who can and cannot access medical records and results of investigations, including those in electronic form
- Be familiar with the laws for mandatory reporting (e.g. unsafe firearm legislation, notifiable diseases) and the Mental Health Act in the relevant jurisdiction
- Reports and certificates (e.g. death certificates, sickness certificates, guardianship reports, medicolegal reports) are legal documents so they must be true and accurate representations of the circumstances

Common pitfalls

- Assuming Indigenous Australian status can be inferred by physical appearance or geographical location
- Documenting someone as non-Indigenous when they have not been asked their Indigenous Australian status
- Not including Indigenous Australian status on relevant documentation
- Leaving questions unanswered

See also

- [Certification >](#)
- [Consent >](#)
- [Establishing Indigenous Australian status >](#)
- [Privacy and confidentiality](#)
- [Telehealth >](#)

Useful resources

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

49. Refusal of treatment

Overview

Some patients may appropriately refuse treatment for a variety of reasons (e.g. religious, financial, geographical, cultural, philosophical, psychological, knowledge of possible side effects). Some patients may inappropriately refuse treatment if they lack capacity, have language difficulties, and/or have not been provided with sufficient information or have inaccurate information.

It is imperative that there is a comprehensive account in the patient record of the patient's refusal of treatment and the measures the doctor has taken to inform the patient of the consequences of refusal, and the other assistance provided both for doctor and patient in the situation. Some jurisdictions and organisations will have refusal of treatment forms to be used in this situation.

Key considerations

- End-of-life care decisions, either by the patient themselves, their legal guardian/power of attorney, or those following an advance care directive should be respected
- If the patient is exhibiting suicidal behaviours, is making the decision for another person (e.g. a child), or is likely to be seriously affected if the treatment is not implemented, then the doctor should consider recourse to legal intervention. This may involve consultation with colleagues, a medical indemnity organisation, hospital administration and/or obtaining a legal opinion.
- The first step is always to explore the reasons for the refusal and to ensure that the patient understands the pros and cons of the treatment. Misinformation from the internet, including social media, should be corrected. Ultimately, unless the situation is likely to be seriously detrimental to the patient, the doctor should respect the patient's decision.

Consideration of specific groups

- Jehovah's Witnesses may refuse blood products
- Mistrust may persist in those communities that have experienced poor treatment or adverse health outcomes in the past
- People experiencing depression may inappropriately refuse treatment as a form of 'passive' suicidal behaviour

See also

- [Conflict of rights of patient with the rights of another person >](#)
- [Involuntary treatment or treatment without consent >](#)
- [Patient-centred care >](#)

Useful resource

- Snow HA, Fleming BR. Consent, capacity and the right to say no. *Med J Aust* 2014; 201: 486-488.

50. Research ethics

Overview

Research is an important means of improving treatment and outcomes for patients. However, patients are vulnerable and may easily feel coerced into, and unable to decline, participation. People may make different decisions when they are sick and dependent than when they are well. Researchers should have respect for (and protect) participants, particularly vulnerable people. Research that is poorly planned, implemented or unnecessary is unethical.

Key considerations

- A junior doctor who is asked to recruit patients, seek consent, or otherwise participate in the research can also be vulnerable if their supervisor is also the researcher. Prior to participating, a junior doctor should be provided with the terms of the ethics approval, the research protocol and contact details of the approving human research ethics committee.
- All research involving humans must be approved by a relevant human research ethics committee
- Careful consideration should be given to participation in research or data gathering where there may be inducements (formal or informal; financial or non-financial)
- Incidental abnormal findings arising from the research that may impact on patient wellbeing should not be ignored
- Informed consent is a process of communication whereby a participant is enabled to make an informed and voluntary decision about accepting or declining participation. Potential participants must have the capacity to decide, and need to be provided with factual information about proposed treatments, procedures, risks, costs and inconveniences.
- Participants' privacy and confidentiality must be respected at all times
- Research should not adversely affect a patient's access to good medical care or their relationship with their treating doctor
- Researchers should be aware of how long documentation must be retained for research purposes, including for specific topics, such as studies in pregnancy
- There is a risk that patients may feel coerced into participation—consent should preferably not be obtained by a doctor who is also in a treating relationship with the patient. Junior doctors should not feel coerced by a senior doctor into obtaining consent.
- There is sometimes a grey area between research and audit/quality improvement. If in doubt, consult an institutional ethics committee.

Consideration of specific groups

- There are circumstances where informed consent can be problematic—where capacity to give informed consent can be difficult (e.g. cognitive impairment, language difficulties, acute psychosis, human embryos, children and minors)
- There are particular guidelines to follow for Aboriginal and/or Torres Strait Islander participants [1]

See also

- [Conflict of interest >](#)
- [Consent >](#)
- [Critical interpretation of data >](#)
- [Involuntary treatment or treatment without consent >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Reference

1. National Health and Medical Research Council. Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: guidelines for researchers and stakeholders. Canberra: NHMRC, 2018. <https://www.nhmrc.gov.au/about-us/resources/ethical-conduct-research-aboriginal-and-torres-strait-islander-peoples-and-communities> (accessed May 2026).

Useful resources

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.
- National Health and Medical Research Council. National statement on ethical conduct in human research. Canberra: NHMRC, 2018. <https://nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018> (accessed May 2026).

51. Resource allocation

Overview

The obligation of clinicians is to make appropriate health care available to their patients in a fair and equitable manner. There is an increasing demand on health care and expensive technology, but resources are finite. This can lead to an inevitable conflict between the best interest of the patient and the interest of society at large. Ethical principles should guide the orderly resolution of such conflicts.

Good medical practice, according to the Medical Board of Australia, involves:

7.2.1 Ensuring that the services you provide are necessary and likely to benefit the patient.

7.2.2 Upholding the patient's right to gain access to the necessary level of healthcare and, whenever possible, helping them to do so.

7.2.3 Supporting the transparent and equitable allocation of healthcare resources.

7.2.4 Understanding that your use of resources can affect the access other patients have to healthcare resources [1].

Key considerations

- Always assess whether the investigations or treatments will make a difference to patient outcomes

See also

- [Advocacy >](#)
- [Charter of healthcare rights >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

Useful resource

- Milroy H, Tonkin A, Walters T, Wilkinson T. Good medical practice: professionalism, ethics and law, 5th ed. Canberra: Australian Medical Council, 2026.

52. Social aspects of health care

Overview

It is imperative that the patient's environmental, geographic, economic and cultural contexts are considered when offering health care. Equitable health outcomes for many patients are not possible due to their social circumstances. The input of social services agencies will assist in some circumstances. Such input includes the appropriate and timely use of interpreters, social workers, non-government organisations, Aboriginal and/or Torres Strait Islander health workers, refugee agencies and government departments. Doctors can use their expertise and influence to protect and advance the health and wellbeing of individual patients, communities and populations.

Key considerations

- Avoid making assumptions about the social circumstances of the individual

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander populations have historical circumstances that can continue to affect their health (see [Historical and political determinants of health](#))
- Access to comprehensive medical care and social assistance is often limited in rural and remote areas
- People of asylum seeker and refugee background continue to be disadvantaged long after arrival in Australia

See also

- [Carer fatigue >](#)
- [Functional decline or impairment >](#)
- [Historical and intergenerational trauma >](#)
- [Interpreters >](#)

Useful resources

- Australian Government. Directory – Department of Social Services. <https://www.directory.gov.au/portfolios/social-services/departments-social-services> (accessed May 2026).
- Australian Government Department of Home Affairs. Translating and Interpreting Services (TIS National). <https://www.tisnational.gov.au> (accessed May 2026).

53. Supervising others and teaching

Overview

It is part of good medical practice to teach, supervise and mentor doctors, medical students and other health professionals. This may include instructing, coaching, supporting, assessing, supervising and providing feedback to colleagues, junior doctors and students.

The Medical Board of Australia's code of conduct states that good medical practice involves:

12.2.1 Seeking to develop the skills, attitudes and practices of an effective teacher, whenever you are involved in teaching.

12.2.2 Making sure that any doctor or medical student for whose supervision you are responsible receives adequate oversight and feedback [1].

Key considerations

- Be aware of boundary issues between a teacher and learner
- Formal training and support of supervisors, teachers and mentors is readily available and recommended
- Patient safety and consent should always take priority
- Role modelling by teachers is a powerful influence on learner behaviour
- Teachers can inadvertently pay more attention, or look more favourably, on learners who share characteristics with them (e.g. by involving learners of the same gender or ethnicity in more teaching episodes; not using the name of people who come from a different culture)
- Teachers should be mindful of trainee wellbeing and safety
- Workplace-based assessments should be honest, constructive and guide learning

See also

- [Boundaries >](#)
- [Continuing professional development >](#)
- [Implicit bias and racism >](#)
- [Improving patient safety by speaking up >](#)
- [Privacy and confidentiality >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Reference

1. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Canberra: Ahpra, 2020. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx> (accessed May 2026).

54. Telehealth

Overview

In Australian health care, telehealth involves various technologies to conduct non-face-to-face medical consultations or to communicate with other health professionals. Telehealth conducted between a doctor and patient may require the presence of other healthcare workers (e.g. nurse, interpreter, carer/guardian, Aboriginal and/or Torres Strait Islander health worker, allied health professional).

Its use is increasing and overcomes some of the issues of limited availability of resources in rural and remote Australia. It is also useful if a patient or a community has a highly contagious disease.

The Australian Government has created an online personal digital health summary called My Health Record (<https://www.myhealthrecord.gov.au>). This contains important information about health conditions, allergies and medications, which people select to include. Items such as immunisations or advance care directives can also be recorded here. Unlike onsite institutional medical records, My Health Record can be accessed by healthcare providers throughout the country. People have an access code that they can supply to healthcare providers. In an emergency, healthcare providers can quickly access this information to improve care. This access can be important for telehealth, for people in remote communities, travellers or in emergency admissions to hospital. There are regulations about who can see this record and penalties for inappropriate access. People can opt out of My Health Record.

Key considerations

- It is possible to transmit additional information and documents (e.g. photo of rash, electrocardiogram, blood pressure and glucose monitoring records, medication list), but this must be done securely
- Setting up telehealth requires particular attention (e.g. adequate facilities, secure and reliable technology, timing, patient consent, privacy and confidentiality, presence of other participants)
- Telehealth and in-person appointments have the same requirements for record keeping, follow-up and handover

Common pitfalls

- Inability to perform a physical examination may affect diagnostic information obtained
- Non-verbal cues may be more difficult to detect
- Telehealth can perpetuate health inequities (e.g. among people with intellectual or sensory deficits, people experiencing socioeconomic hardship and resulting impaired access to technology, people experiencing homelessness)
- Telehealth may negatively affect the doctor–patient relationship or the patient’s perception of the consultation

Consideration of specific groups

- Aboriginal and/or Torres Strait Islander people in remote areas
- Children
- People with disabilities, including mobility, communication and cognitive impairment

See also

- [Patient images and photos >](#)
- [Privacy and confidentiality >](#)
- [Record keeping, medicolegal issues and mandatory reporting >](#)

Useful resource

- Royal Australasian College of Physicians. Telehealth: guidelines and practical tips. Sydney: RACP, 2013. <https://www.racp.edu.au/docs/default-source/advocacy-library/telehealth-guidelines-and-practical-tips.pdf> (accessed May 2026).

55. Well baby check

Overview

Newborn babies require a thorough examination to look for abnormalities within the first few days of life and again at 4–6 weeks of age. Some presentations are not apparent at birth due to circulatory changes or feeding problems. The purpose of a newborn baby check is to detect congenital anomalies, particularly those that benefit from early intervention. Hearing checks and blood tests for inborn errors of metabolism are routinely undertaken in every hospital in Australia. Most newborn babies have no abnormalities.

Key considerations

- Heart murmurs, particularly due to septal defects, may only appear after the pulmonary blood pressure has dropped after birth
- It is important to consider the impact of any medications or maternal illnesses, such as bloodborne viruses or autoimmune diseases
- Well baby checks provide an opportunity for parental education regarding immunisation, normal nutrition, growth and development

See also

- [Immunisations >](#)

56. Well person check and screening

Overview

The aim of a well person check is to detect undiagnosed problems or risk factors that benefit from early intervention. Some are required as part of insurance applications. Although it can reassure people who are healthy but who have health concerns or health anxiety disorder, overdiagnosis and overtreatment can worsen such anxieties.

Other disadvantages of screening include a lack of evidence that early detection always results in better outcomes, and the risk of over-investigation and undue anxiety.

Key considerations

- Be aware of conditions for which there are conflicting views about the benefits of screening (e.g. prostate cancer, genetic disorders)
- Be aware of conditions for which there is consensus on the benefits of screening (e.g. cervical cancer)
- Consider implications if a screening test result is positive, and discuss with the patient before proceeding with the investigation (e.g. Huntington disease, cancer)
- Particular at-risk individuals and populations may require more targeted advice and screening
- Routine checks can be used to monitor risk factors for systemic disease (e.g. blood pressure check, screening for diabetes mellitus)
- Treatment is contentious for some findings (e.g. early prostate cancer, small papillary thyroid cancer, in situ intraductal breast carcinoma), which could embark the patient on an unnecessary treatment course
- Well person checks can be an opportunity to provide general lifestyle advice (e.g. diet; exercise; tobacco, alcohol and recreational drug use)

Consideration of specific groups

- Groups who are less likely to participate in screening programs include:
 - Aboriginal and/or Torres Strait Islander people
 - other First Nations populations
 - Pacific Islander people
 - LGBTQI (lesbian, gay, bisexual, transgender, queer and intersex) people
- Women receiving antenatal care

See also

- Abnormal test results >
- Critical interpretation of data >
- Genetic testing and DNA sovereignty >
- Immunisations >
- Motivational interviewing, lifestyle advice and brief interventions >

Useful resource

- Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. The Red book, 10th ed. Melbourne: RACGP, 2024. <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/preventive-activities-in-general-practice/about-the-red-book> (accessed May 2026).

Conditions

The following conditions have been referred to in this book. This list of conditions can be used as a checklist of areas with which to be familiar. There has been no attempt to assign any priority to these conditions, nor to explain the depth of knowledge required. Essentially, the knowledge of conditions needs to be sufficient to manage a doctor's individual case load—some will need in-depth knowledge on treatment, whereas others simply need to be considered as part of a differential diagnosis, where further investigation and treatment might be better undertaken by those with more specialised knowledge. As a guide, serious life-threatening or treatable conditions should always be on the list to consider. The more prevalent conditions will need greater in-depth knowledge on investigation and treatment.

1. 'Growing pains' 77
2. Abdominal aortic aneurysm 54
3. Abdominal hernia 54
4. Abnormal sperm morphology 159
5. Abscess 54, 135, 144, 181, 208
6. Achalasia 111
7. Acidosis 72, 95
8. Acne 208
9. Acoustic neuroma 114
10. Actinic (solar) keratosis 208
11. Acute glaucoma 151
12. Acute stress disorder 68, 224
13. Adjustment disorder 68, 172, 203
14. Agoraphobia 68
15. Airway obstruction 87
16. Alcohol excess 64, 155, 157, 167
17. Alcohol use 113, 115, 127, 167, 184, 205, 212, 214, 226, 236
18. Alcohol withdrawal 68, 201
19. Allergic reaction 74, 105, 122, 171, 210, 212
20. Alzheimer disease 95
21. Amyloidosis 135
22. Anaemia 129, 190, 236
23. Anal fissure 199
24. Anaphylaxis 74, 105, 174, 207
25. Angina 89, 221
26. Angiodysplasia 199
27. Angioedema 174
28. Ankylosing spondylitis 70
29. Antepartum haemorrhage 197

30. Anti-sperm antibodies 159
31. Anxiety 79, 89, 103, 107, 111, 113, 115, 129, 140, 161, 163, 179, 190, 205, 217, 224
32. Aortic aneurysm 52, 85
33. Aortic coarctation 60, 155
34. Aortic dissection 52, 89, 125, 207
35. Aortic regurgitation 56
36. Aortic stenosis 56, 125
37. Aorto-duodenal fistula 199
38. Aorto-enteric fistula 235
39. Apnoea of prematurity 101
40. Appendicitis 51, 192, 197
41. Arrhythmias 60, 87, 113, 125
42. Arterial hypertension
43. Arterial insufficiency 85, 176, 212
44. Arteriovenous malformations 99
45. Arteritis 85
46. Arthropathy 236
47. Ascites 54
48. Aspirated foreign body 103
49. Aspiration 87, 105
50. Aspiration pneumonia 99
51. Asthma 60, 87, 99, 103, 105
52. Atherosclerosis 85
53. Atopic dermatitis 210
54. Atrial fibrillation 113, 125, 190
55. Atrial flutter 113, 125, 190
56. Attention deficit hyperactivity disorder 73, 203
57. Autism spectrum disorder 68, 73, 102, 109, 188, 203
58. Autoerotic asphyxiation 94
59. Autoimmune and connective tissue diseases 120, 135, 148, 169, 210, 236
60. Autonomic neuropathy 125
61. Avascular necrosis of the hip 169
62. Azoospermia 159
63. Backache 195
64. Bacteraemia 131
65. Bacterial endocarditis 56
66. Barotrauma 118
67. Barrett oesophagus 157
68. Bartholin cyst 144
69. Basal cell carcinoma 118, 208
70. Behavioural problems 133
71. Behçet disease 174, 212
72. Benign intracranial hypertension 151
73. Benign oesophageal stricture 111
74. Benign paroxysmal positional vertigo 114

- 75. Bereavement and grief 129
- 76. Biliary atresia 51, 167
- 77. Biliary colic 51, 89
- 78. Biliary obstruction 167
- 79. Bipolar affective disorder 172, 188, 203
- 80. Bladder calculi 192
- 81. Bleeding disorders 76, 183, 235
- 82. Blepharitis 120
- 83. Blocked lacrimal duct 122
- 84. Body dysmorphic disorder 68, 188
- 85. Bone bruising 77
- 86. Borderline and/or antisocial personality disorder 59, 203
- 87. Bowel obstruction 51, 54, 72
- 88. Brain injury 59, 215, 219
- 89. Brainstem compression 87
- 90. Branchial cyst 174, 181
- 91. Breast abscess 78, 79
- 92. Breast cancer 78
- 93. Breast cyst 78
- 94. Breast engorgement 79
- 95. Bronchiectasis 99, 105
- 96. Bronchiolitis 60, 105
- 97. Bronchitis 99
- 98. BRUE 101
- 99. Bruxism 151, 221
- 100. Bulbar or pseudobulbar palsy 111
- 101. Bursae 208
- 102. Cancer 140, 179
- 103. Candidiasis 72, 111, 144, 146
- 104. Capsulitis and bursitis 169
- 105. Cardiac failure 95, 103, 171
- 106. Cardiac rupture 87
- 107. Cardiomyopathy 190
- 108. Carpal tunnel syndrome 184
- 109. Cataracts 66
- 110. Cauda equina compression 70
- 111. Cavernous sinus thrombosis 122
- 112. Cellulitis 118, 176, 208
- 113. Cerebellar disease 114
- 114. Cerebral haemorrhage 96
- 115. Cerebral hemisphere lesion 184
- 116. Cerebral palsy 102, 133, 142, 161
- 117. Cerebral space-occupying lesion 142, 236
- 118. Cerebrospinal fluid (CSF) leak 183
- 119. Cerebrovascular disease or cerebral injury 64, 66, 95, 114, 140, 161

- 120. Cervical insufficiency
- 121. Cervical lymphadenopathy
- 122. Cervical spine disease
- 123. Cervical spondylosis 151
- 124. Cervical stenosis 159
- 125. Chalazion 120
- 126. Chest wall weakness 103
- 127. Chlamydia 144, 146
- 128. Choledocholithiasis 167
- 129. Cholestasis of pregnancy 167, 195, 210
- 130. Cholesteatoma 118, 153
- 131. Chondromalacia patellae 169
- 132. Chronic fatigue syndrome 129, 176
- 133. Chronic obstructive lung disease 105
- 134. Chronic pain 203
- 135. Circadian sleep disorder 107
- 136. Cirrhosis 167
- 137. Cluster headaches 151
- 138. Coagulopathy 74, 99
- 139. Coeliac disease 62, 123
- 140. Collagen vascular disease 56
- 141. Colon cancer 199
- 142. Common cold 183
- 143. Complex regional pain syndrome 176
- 144. Conductive deafness 153
- 145. Congenital adrenal hyperplasia 60
- 146. Congenital cataracts
- 147. Congenital heart disease 56, 60, 101, 123, 133
- 148. Congenital uterine anomaly 197
- 149. Conjunctivitis 120, 122
- 150. Constipation 51, 54, 62, 72, 192, 228
- 151. Contraception failure 226
- 152. Conversion disorder 64, 236
- 153. Costochondritis 89
- 154. Cow's milk protein intolerance 62, 123
- 155. Cracked nipples 79
- 156. Cramps 176
- 157. Cranial arteritis 151
- 158. Croup 174
- 159. Cushing syndrome 155, 186, 236
- 160. Cystic fibrosis 99, 105, 123
- 161. Cysts 208
- 162. Deconditioning 113, 236
- 163. Decubitus ulcers 212
- 164. Deep vein thrombosis 85, 135, 171

- 165. Dehydration 113, 115, 151, 176, 179, 218
- 166. Delirium 58, 95, 140
- 167. Dementia 59, 68, 95, 111, 140
- 168. Dementia with Lewy bodies 95
- 169. Dental abscess 221
- 170. Dental caries 72, 174, 221
- 171. Dependent oedema 171
- 172. Depression 68, 79, 95, 107, 113, 129, 133, 140, 163, 188, 205, 224, 236
- 173. Depression with mutism 109
- 174. Depression with psychosis 58, 203
- 175. Dermatitis artefacta 212
- 176. Dermatofibroma 208
- 177. Dermatomyositis 176, 236
- 178. Developmental dysplasia of the hip 169
- 179. Diabetes insipidus 218
- 180. Diabetes mellitus 107, 125, 155, 176, 184, 195, 205, 212, 218, 229
- 181. Diabetic ketoacidosis 64
- 182. Dislocations and fractures 169
- 183. Dissecting aneurysm 56
- 184. Divarication of the rectus muscles 54
- 185. Diverticular disease 51, 192, 199
- 186. Donovanosis 144, 146
- 187. Down syndrome 102
- 188. Drug overdose
- 189. Drug side effects 59, 62, 76, 81, 95, 99, 103, 105, 107, 109, 113, 115, 129, 135, 142, 148, 151, 153, 155, 157, 161, 163, 167, 171, 176, 179, 181, 183, 184, 186, 201, 205, 214, 215, 217, 218, 219, 228, 235, 236
- 190. Drug use 95, 113, 115, 125, 127, 129, 151, 176, 183, 190, 205, 226, 236
- 191. Drug withdrawal 68, 151, 176, 190, 201
- 192. Dry eye syndrome 120
- 193. Dry skin 210
- 194. Dupuytren contracture 169
- 195. Dysmenorrhoea 192
- 196. Dyspareunia 159
- 197. Dysphoric milk ejection reflex 79
- 198. Earwax 153, 219
- 199. Eating disorder 179, 186, 188, 203, 224, 234
- 200. Eclampsia 195, 201
- 201. Ectopic beats 190
- 202. Ectopic pregnancy 51, 52, 192, 230
- 203. Ectropion 230
- 204. Eczema 210
- 205. Elective mutism among children
- 206. Electrolyte disturbances 95, 129, 140, 190, 218, 236
- 207. Embolism 85, 89

208. Encephalitis 59, 64, 165, 201
209. Endocarditis 169
210. Endocrinopathies 229
211. Endometriosis 62, 159, 192, 199, 205, 230
212. Enthesitis 176
213. Entropion 120
214. Envenomation 74, 171
215. Epidermoid cyst 181
216. Epididymitis 146, 228
217. Epiglottitis 105, 174
218. Epilepsy 59, 60, 64, 95, 125, 201
219. Erectile disorders 159
220. Erythema ab igne 210
221. Essential hypertension 155
222. Essential tremor 161
223. Factitious disorder 64, 142
224. Factitious disorder by proxy 163, 234
225. Fallot tetralogy 56
226. Familial Mediterranean fever 135
227. Fatigue 195, 205
228. Female genital mutilation 144, 229
229. Female-pattern baldness 148
230. Fetal alcohol spectrum disorder 102, 203
231. Fibroadenoma 78
232. Fibroid degeneration in pregnancy 192
233. Fibroids 230
234. Fibromuscular disease 85
235. Fibromyalgia 129, 176
236. Folliculitis 208
237. Food intolerance 62, 133, 157, 165, 179
238. Foreign body aspiration 72, 99, 105, 111, 118, 120, 122, 153, 174, 183, 192, 229, 232
239. Foreign body trauma 72, 99, 111, 118, 120, 122, 153, 174, 183, 192, 229, 232
240. Freckles 208
241. Fronto-temporal dementia 95
242. Fungal infection 146, 148, 178, 228
243. Galactorrhoea 78
244. Ganglia 208
245. Gastritis 89, 157, 235
246. Gastro-oesophageal reflux disease 51, 72, 89, 94, 99, 107, 109, 111, 133, 157, 165, 179, 195
247. Gastroenteritis 51, 60, 62, 179
248. Gastrointestinal cancer 51, 62, 157
249. Gastrointestinal cancers
250. Gastrointestinal tract obstruction 179
251. Gender dysphoria 68
252. Generalised anxiety disorder 68, 188

- 253. Genetic developmental disorders 186
- 254. Genital warts 144, 146
- 255. Genitourinary syndrome of menopause 205, 230, 232
- 256. Gestational trophoblastic disease 230
- 257. Gingivitis 76
- 258. Glandular fever 163
- 259. Glaucoma 66, 120
- 260. Global developmental delay 102
- 261. Globus pharyngeus 111
- 262. Glomerulonephritis 155, 229
- 263. Glossitis
- 264. Goitre 105, 111
- 265. Gonorrhoea 144, 146
- 266. Gout and pseudogout 169
- 267. Graves disease 122
- 268. Growth hormone deficiency 186
- 269. Guillain–Barré syndrome 236
- 270. Gynaecomastia 78
- 271. Haemangioma 208
- 272. Haemarthrosis 169
- 273. Haemolysis 74, 167
- 274. Haemolytic disease of the newborn 167
- 275. Haemophilia 81
- 276. Haemorrhoids 195, 199
- 277. Hand foot and mouth disease 210
- 278. Hayfever 122, 183
- 279. Head injury 64, 95, 151
- 280. Head lice 210
- 281. Heart block 113, 125
- 282. Heart failure 129, 140, 167
- 283. Heat rash 210
- 284. Heat stroke 125
- 285. Helminthic infection 135, 163
- 286. Henoch–Schönlein purpura 81, 210
- 287. Hepatitis 163, 167
- 288. Herbal preparation side effects 167
- 289. Herpes simplex 120, 144, 146, 184, 228
- 290. Herpes stomatitis 174
- 291. Herpes zoster 52, 89, 118, 146, 151, 184, 210
- 292. Hiatus hernia 89
- 293. Hidradenitis suppurativa 208
- 294. HIV infection 163, 181
- 295. Huntington chorea 161
- 296. Hydrocephalus 151
- 297. Hydrocoele 146

- 298. Hyperaldosteronism 155
- 299. Hyperemesis gravidarum 179, 226
- 300. Hypertensive encephalopathy 96
- 301. Hypertension 107, 195
- 302. Hyperthyroidism 68, 107, 123, 140, 163, 217
- 303. Hyperventilation 113, 125, 184
- 304. Hypo-albuminaemia 171
- 305. Hypoglycaemia 60, 64, 95, 113, 125, 201, 217
- 306. Hypothyroidism 62, 109, 129, 140, 148, 167, 186, 236
- 307. Hypoxia 64, 87
- 308. Hypoxic ischaemic encephalopathy 201
- 309. Impacted wisdom teeth 118
- 310. Impetigo 208, 210
- 311. Implantation bleeding 230
- 312. Inborn errors of metabolism 60, 123
- 313. Incarcerated hernia 52
- 314. Incisional hernia 54
- 315. Immunosuppression
- 316. Infantile colic 165
- 317. Infantile spasms 201
- 318. Infection (bacterial, viral, fungal) 129, 135, 140, 144, 171, 192, 212, 217, 232
- 319. Inflammatory arthritides 142
- 320. Inflammatory bowel disease 52, 62, 169, 199, 212
- 321. Inguinal hernia 54, 144, 146
- 322. Insect-borne viruses 74, 169
- 323. Intellectual disability 73, 203
- 324. Intervertebral disc disease
- 325. Intra-abdominal abscess 52
- 326. Intra-abdominal haemorrhage 54
- 327. Intra-abdominal or pelvic malignancy 54
- 328. Intra-ocular or intracranial malignancies 66
- 329. Intracranial lesions and bleeds 68, 151, 165, 201
- 330. Intrauterine contraceptive device 232
- 331. Intravenous cannula infection 135
- 332. Intussusception 60, 165
- 333. Inverted nipples 79, 133
- 334. Iritis 120
- 335. Iron deficiency anaemia 111, 165
- 336. Irritable bowel syndrome 51, 54, 62, 157, 192
- 337. Irritable hip or transient synovitis among children 169
- 338. Ischaemic colitis 62, 199
- 339. Ischaemic heart disease 89, 125, 190
- 340. Juvenile idiopathic arthritis 165, 169
- 341. Kawasaki disease 131, 181
- 342. Keratitis 120

- 343. Koilonychia 178
- 344. Labyrinthitis 114, 179
- 345. Laryngeal cancer 109, 111
- 346. Laryngeal oedema 105
- 347. Laryngitis 174
- 348. Lateral medullary syndrome 114
- 349. Laxative and diuretic misuse 234
- 350. Leprosy 184
- 351. Leucorrhoea of pregnancy 232
- 352. Leukaemia 76, 77, 81, 165, 217
- 353. Lichen sclerosus 144, 205
- 354. Lipoma 208
- 355. Liver disease 54, 72, 81, 129, 178, 210
- 356. Liver failure 64, 95, 161, 171
- 357. Long QT syndrome 190
- 358. Lower respiratory tract infection 60, 99, 101, 103, 135, 174
- 359. Lung abscess 72, 99
- 360. Lung malignancy 89, 99, 103, 105
- 361. Lyme disease 74, 236
- 362. Lymphadenopathy 146, 181, 183
- 363. Lymphatic obstruction 171
- 364. Lymphoma 81, 135, 217
- 365. Macular degeneration 66
- 366. Major depressive disorder 62, 172, 203
- 367. Malabsorption syndromes 163
- 368. Malaria 74, 135
- 369. Male-pattern baldness 148
- 370. Malignancy 129, 138, 163, 174, 230
- 371. Malingering 64
- 372. Mallory–Weiss tears 235
- 373. Malnutrition 148
- 374. Malrotation with volvulus in infant 179
- 375. Mania and hypomania 58, 107, 215
- 376. Marfan syndrome 56
- 377. Marjolin ulcer 212
- 378. Mastitis 78, 79
- 379. Mastoiditis 118
- 380. Measles 131, 210
- 381. Meckel diverticulum 199
- 382. Meconium aspiration syndrome 101
- 383. Meibomian cyst 122
- 384. Melanoma 208
- 385. Ménière disease 114, 127, 142, 153, 219
- 386. Meningitis 64, 131, 152, 165, 201
- 387. Meningococcal sepsis 210

- 388. Menopause 107, 217
- 389. Mesenteric ischaemia 52
- 390. Metabolic acidosis
- 391. Metastatic malignancy 70, 77, 181
- 392. Migraine 59, 66, 151, 179, 184
- 393. Miliaria 210
- 394. Miscarriage 192, 195, 230
- 395. Mitral regurgitation 56
- 396. Mitral stenosis 56
- 397. Motion sickness 114, 179
- 398. Motor neurone disease 109, 129, 236
- 399. Mouth ulcers 111, 174
- 400. Multiple gestation 195
- 401. Multiple myeloma 77, 81
- 402. Multiple sclerosis 129, 142, 153, 184
- 403. Mumps orchitis 146
- 404. Muscular dystrophy 102, 142, 236
- 405. Musculoskeletal pain 52, 70, 89
- 406. Myalgia 176
- 407. Myasthenia gravis 109, 129, 236
- 408. Myocardial infarction 207
- 409. Myocardial ischaemia 52, 89, 157
- 410. Myopathy 102, 133, 142, 176
- 411. Naevi 208
- 412. Nappy rash 144, 146
- 413. Narcolepsy 107
- 414. Nasal polyp 183
- 415. Nasopharyngeal tumours 183
- 416. Nephrotic syndrome 122, 171
- 417. Nerve compression and entrapment 176, 184, 236
- 418. Nerve root disease 229, 236
- 419. Neuropathic joint 169
- 420. Neuropathic ulcers 212
- 421. Nocturnal myoclonus 107
- 422. Noise-associated hearing loss 219
- 423. Non-accidental injury 60, 81, 138, 149, 165
- 424. Non-alcoholic steatohepatitis 167
- 425. Non-ulcer dyspepsia 51, 157
- 426. Nutritional deficiencies 96, 140, 178
- 427. Obesity 54, 155, 157, 205, 214, 217
- 428. Obsessive–compulsive disorder 68, 163, 188, 234
- 429. Obstructive cardiomyopathy 125
- 430. Obstructive sleep apnoea 105
- 431. Occupational lung disease 103
- 432. Oesophageal cancer 89, 111

- 433. Oesophageal reflux
- 434. Oesophageal varices 235
- 435. Oesophagitis 89, 165, 235
- 436. Oligospermia 159
- 437. Onychogryphosis 178
- 438. Oppositional defiance disorder 73
- 439. Orbital cellulitis 122
- 440. Orbital fracture 122
- 441. Oropharyngeal cancer 221
- 442. Osgood–Schlatter disease 77
- 443. Osteoarthritis 85, 142, 169
- 444. Osteochondritis 77
- 445. Osteogenesis imperfecta 138
- 446. Osteoma 118
- 447. Osteomyelitis 77, 131, 135, 143, 165
- 448. Osteonecrosis of jaw or tooth socket 221
- 449. Osteoporosis 138
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Appendix

Common causes of death and common problems seen in general practice and emergency departments

The lists below are derived from a national study of general practitioner clinical activity in 2016 [1].

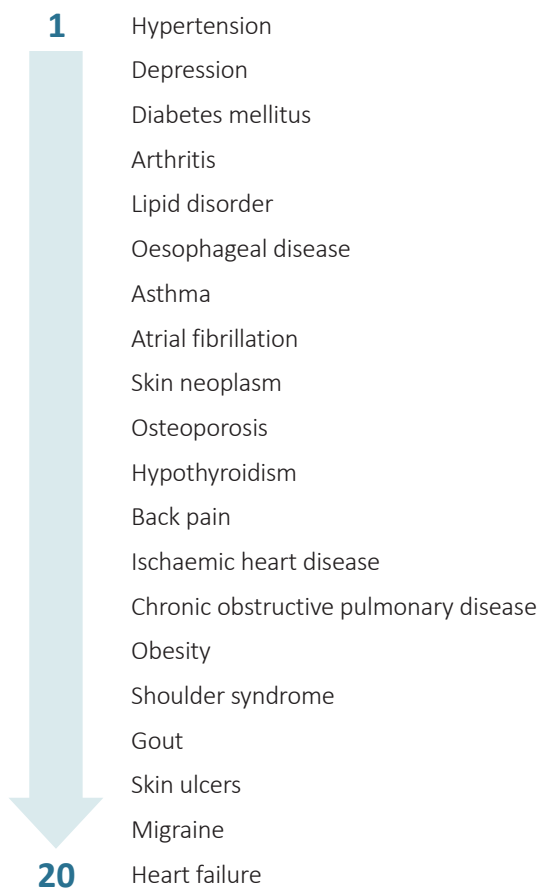
The **top 20** most frequently managed problems in the general practice setting in Australia:

1

- Hypertension
- Upper respiratory tract infection
- Immunisation
- Depression
- Diabetes mellitus
- Arthritis
- Back pain
- Lipid disorder
- Gastro-oesophageal reflux disease
- Anxiety
- Asthma
- Acute bronchitis
- Urinary tract infection
- Dermatitis
- Sleep disturbance
- Screening for cervical cancer
- Nutritional deficiency
- Gastroenteritis
- Bursitis and tendonitis
- Atrial fibrillation

20

The **top 20** most frequently managed *chronic* problems in the general practice setting in Australia:



The **most common** reasons for presentation to an emergency department in Australia:

1

Abdominal and pelvic pain

Chest pain

Viral infections

Cellulitis

Open wound—head

Injury

Gastroenteritis

Dorsalgia

Acute upper respiratory tract infection

Open wound—hand

Urinary disorders

Dislocation, sprain—ankle and foot

Fracture—wrist and hand

Syncope and collapse

Fracture—forearm

Nausea and vomiting

Pneumonia

Soft tissue disorders

Asthma

20

Superficial head injury

The **most common** causes of death in Australia:

1



Ischaemic heart disease
Dementia
Cerebrovascular diseases
Malignant neoplasm of lung
Chronic lower respiratory diseases
Malignant neoplasm of colon
Diabetes mellitus
Malignant neoplasms of blood
Heart failure
Diseases of the urinary system
Influenza and pneumonia
Malignant neoplasm of prostate
Malignant neoplasms of breast
Malignant neoplasm of pancreas
Suicide
Accidental falls
Cardiac arrhythmias
Hypertensive diseases
Melanoma

20

Malignant neoplasm of liver

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