



The Royal Australian  
College of General  
Practitioners

# *The RACGP Curriculum for Australian General Practice 2011*



**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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# Foreword

*The RACGP Curriculum for Australian General Practice 2011* builds on the strengths of the previous 2007 curriculum and *The RACGP Training Program Curriculum 1998*. It is a truly collective effort which codifies countless hours of general practice experience into a solid professional foundation for the high quality education and training of our future general practitioners.

In February 2011, The Royal Australian College of General Practitioners Council identified the need to renew the curriculum for Australian general practice training.

The Council recognised that the previous curriculum was robust and sound, but would need to be updated to include the newer, contemporary core competencies that are necessary for practising within an evolving general practice environment. The rise of e-health, the requirements of leadership and management, quality and safety concerns and the increasing role of teaching and research in general practice within the context of multidisciplinary primary care, all present educational and training challenges. Updating the general practice curriculum is the first step on the path to incorporating these skills into the lifelong learning of GPs.

Curricula are very much the domain of educators, and so the next step will be the development of curriculum learning supports for general practice registrars and teaching guides for educators to help meet training requirements. For this reason, an updated edition of *The RACGP Curriculum Companion* will be published. The College will seek input from registrars and general practice educators around Australia to assist in the production of these valuable resources.

Future planned curriculum developments will include online interactive tools to assist learners and educators. This will ensure that the collective wisdom and professional expertise of generations of GPs are passed on effectively and efficiently.

Curriculum renewal is an ongoing process because of the changing environment of medicine and general practice. Continual feedback is encouraged and we welcome feedback through the RACGP website. Ongoing maintenance of *The RACGP Curriculum for Australian General Practice* will be facilitated by the RACGP National Standing Committee for Education.

The 2011 curriculum is the beginning of a renewal process that will provide continuing and relevant support to learners and educators to assist GPs in acquiring the necessary skills, knowledge and attitudes to provide high quality general practice care, training and research within the modern world that is Australian general practice.

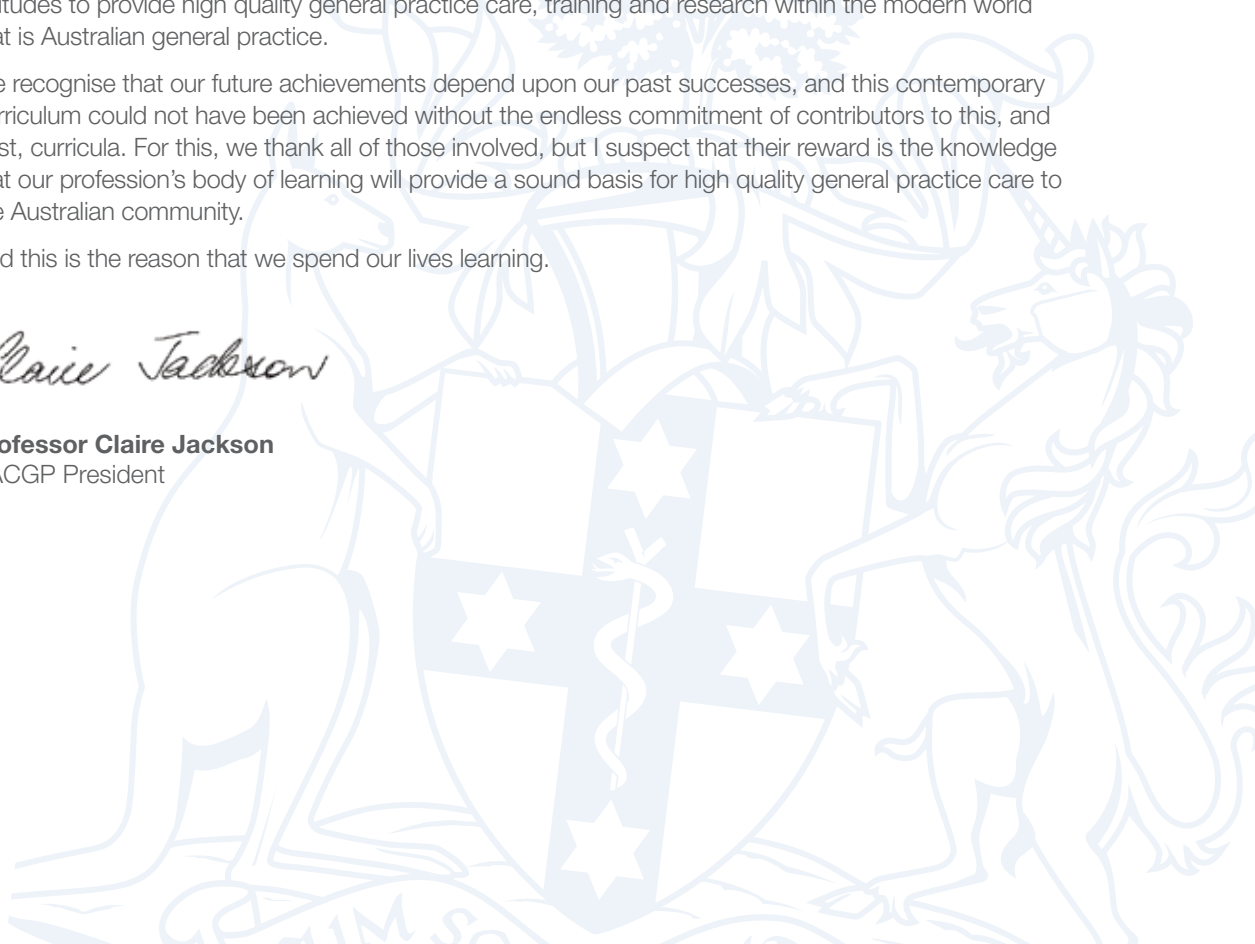
We recognise that our future achievements depend upon our past successes, and this contemporary curriculum could not have been achieved without the endless commitment of contributors to this, and past, curricula. For this, we thank all of those involved, but I suspect that their reward is the knowledge that our profession's body of learning will provide a sound basis for high quality general practice care to the Australian community.

And this is the reason that we spend our lives learning.



Claire Jackson

**Professor Claire Jackson**  
RACGP President





# Contents

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## Acknowledgments

	i
2011 curriculum reviewers	ii
Curriculum definition, purpose and development	vi
Guide to using the curriculum	viii
Context of Australian general practice	xi
Learning life of general practitioners	xii
The five domains of general practice	xvii
The star of general practice and development of a new curriculum framework	xviii
Curriculum feedback	xx

## General curriculum statement chapters

Common training outcomes	21
Philosophy and foundation of general practice	33

## Specific curriculum statement chapters

### People and their populations

Aboriginal and Torres Strait Islander health	51
Aged care	61
Children and young people's health	77
Disability	95
Doctors' health	109
Genetics	123
Men's health	135
Multicultural health	149
Population health and public health	167
Rural general practice	181
Women's health	197

### Presentations

Acute serious illness and trauma	211
Chronic conditions	227
Dermatology	249
Drug and alcohol medicine	265
Eye and ear medicine	279
Mental health	293
Musculoskeletal medicine	313
Occupational medicine	331
Oncology	343
Palliative care	355
Pain management	369
Sexual health	383
Sports medicine	397

### Processes of general practice

Critical thinking and research	409
Undifferentiated conditions	423
E-health	439
Multidisciplinary care	451
Integrative medicine	467
Quality and safety	481
Practice management	497
Procedural skills	513
Quality use of medicines	527
Teaching, mentoring and leadership in general practice	549



# Acknowledgments

The Royal Australian College of General Practitioners (RACGP) wishes to acknowledge that the *Curriculum for Australian General Practice 2011* builds on the strengths of the previous 2007 curriculum and *The RACGP Training Program Curriculum 1998*.

The RACGP Council recognised that the 2007 curriculum is robust and sound. Acknowledgment for their work can be found on the College website at:

- [www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/20070115Workinggroupschairpersons.pdf](http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/20070115Workinggroupschairpersons.pdf)
- [www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/200610NSCCurriculumReview.pdf](http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/200610NSCCurriculumReview.pdf)
- [www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/200610Writinggroup.pdf](http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/curriculum/200610Writinggroup.pdf)

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Curriculum Renewal Working Group

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# Curriculum definition, purpose and development

*The RACGP Curriculum for Australian General Practice 2011* ('the curriculum') details what vocational general practitioners need to learn throughout their general practice learning life. The curriculum details the knowledge, skills and attitudes that GPs require for:

- competent, unsupervised general practice
- meeting their community's healthcare needs
- supporting current national health priorities and the future goals of the Australian healthcare system.

The curriculum emphasises self directed learning, the development of critical self reflection and lifelong learning skills, and the maintenance of professional practice standards.

## Who is the curriculum for?

The curriculum is an essential reference for general practice registrars, general practice supervisors, medical educators, regional training providers and anyone involved in the implementation of the training of future GPs. For this reason, the curriculum also details learning objectives for medical students and prevocational doctors. The acquisition of these skills may also be of interest to many medical specialists.

## Curriculum development

The 2011 curriculum was developed by updating on the already significant achievements of the 2007 curriculum and the 1998 training program curriculum. Development of the 2011 curriculum took into account:

- the discipline of general practice as a medical specialty
- what GPs need to know ('the domains of general practice')
- the lifelong learning needs of GPs (from medical student through to prevocational doctor, vocational training and continuing professional development)
- the reasons most people seek the services of a GP ('common patient presentations')
- the evolving general practice environment since the last edition of the curriculum.

Using this framework, new curriculum statements were developed and existing statements revised, detailing the training and educational outcomes that relate to various populations, presentations and processes in Australian general practice.

## How has the curriculum changed since 2007?

*The RACGP Curriculum for Australian General Practice 2011* incorporates new educational and training needs that have risen out of the evolving Australian general practice environment such as:

- the increasing focus on competency based training in a move away from a traditional apprenticeship based model
- the incorporation of identified contemporary competencies that need to be added to the GP's traditional skill set, especially management, teaching, research, quality and safety, teamwork, e-health and leadership

- the incorporation of updated information on the general practice environment, such as Australian general practice statistics, new RACGP initiatives and policies and changing Australian Government policies
- the incorporation of feedback and comments received since publication of the 2007 curriculum
- reformatting of the curriculum content. This was required to increase accessibility, utility and user-friendliness, especially for general practice registrars, general practice supervisors, regional training providers and general practice educational providers.

## Implementation of the curriculum update

The RACGP Council appointed a Curriculum Review Working Group to systematically update the 2007 curriculum content to meet these aims. The RACGP Council recognised that the 2007 curriculum content was sound and robust, and that the main task was one of updating and not rewriting.

The Curriculum Review Working Group reviewed each of the statements with respect to embedding these concepts throughout the curriculum. Each statement was then reviewed by expert reviewers prior to Censor-in-Chief approval.

In addition, specific measures for each of the identified newer contemporary core competencies were incorporated into the curriculum and underwent expert general practice review prior to final RACGP Council review.

## Introduction of training outcomes

The 2011 curriculum introduces a new section entitled, 'Training outcomes'. This section replaces the description of skills in the previous curriculum inline with the trend toward outcome based training.

A training outcome is a specific focus on a particular attribute (skill, knowledge or attitude) expected of learners at the end of general practice training. This reformatting clarifies specific expected competencies by the completion of general practice vocational training.

Most of these training outcomes were listed in the 2007 curriculum, apart from a small number of outcomes associated with the above identified newer contemporary core competencies.

Each training outcome now has an associated code, as detailed in the section 'Guide to using the curriculum'. The new format of the 2011 curriculum is designed to enable and facilitate discussion and incorporation of specific educational requirements into training programs.

The numbering of competencies and learning objectives will also assist in the mapping of the curriculum to training programs.

# *Guide to using the curriculum*

## Curriculum background

The background to the curriculum provides the basis for the content, structure and development of the curriculum. The key areas of the 2011 curriculum are:

- Definition, purpose and development
- Context of Australian general practice
- Learning life of general practitioners
- The five domains of general practice
- The 'star of general practice' and development of a new curriculum framework.

## Curriculum statement areas

### General curriculum statement chapters

There are two general curriculum statements:

- Common learning outcomes defines common training outcomes and learning objectives for general practice relevant to consulting with patients in unsupervised general practice
- Philosophy and foundation of general practice includes the philosophy, concepts and principles that define the roles of GPs and the discipline of general practice.

### Specific curriculum statement chapters

The specific curriculum statement chapters are arranged into three major sections:

- People and their populations
- Presentations
- Processes of general practice.

A full list of the statement chapters appears at the end of this section.

## Key features of each curriculum statement

Each statement is divided into the following key areas:

- Definition
- Curriculum in practice
- Rationale and general practice context
- Training outcomes of the five domains of general practice
- Learning objectives across the GP professional life.

### Definition

Defines the role of a particular area of health within the general practice setting.

### Curriculum in practice

This section provides case studies that illustrate how the curriculum statement area relates to general practice. These may be used for teaching and discussion in conjunction with the curriculum.

## Rationale and general practice context

This section documents how the statement area relates to the context of Australian general practice. It focuses the learning and training outcomes to meet the specific general practice needs of the Australian community.

## Training outcomes of the five domains of general practice

The specific outcomes of general practice training are described in this section. It focuses on the attributes (skills, knowledge and attitudes) expected of learners at the end of each stage of training across the five domains of general practice.

### Training outcomes numbering

The training outcomes are numbered for easy referencing and mapping across the broad range of general practice training, learning and assessment programs and processes.

Each training outcome code/number consists of:

- a unique three letter code which identifies the statement area that the specific training outcome comes from
- followed by a 'T' to indicate that the specific curriculum code refers to a 'training outcome'
- this is followed by the domain number (see *the five domains of general practice*)
- which is followed by the curriculum item number.

For example:

DER1.2 identifies the second training outcome of the first domain (ie. communication) in the *Dermatology* statement.

## Learning objectives across the GP professional life

This section describes the objectives of education and training for each stage of the GP's learning life. The objectives in this section are stated in measurable outcomes for the educational benefit of learners and teachers. This enables lesson planning and assessing learning outcomes across the general practice learning life.

Note that each learning objective level assumes a previously attained learning (as detailed in the previous level). For example, the vocational registrar level assumes that the previous learning objectives of the prevocational doctor and the medical student have been attained.

### Learning objectives numbering

The learning objectives are numbered for easy referencing and mapping across the broad range of general practice training, learning and assessment programs and processes.

Each learning objective code/number consists of:

- a unique three letter code which identifies the statement area that the specific training outcome comes from
- followed by an 'L' to indicate that the specific curriculum code refers to a 'learning objective'
- this is followed by 'M', 'P', 'V' or 'C' to indicate the learning life level of the objective (M = medical student, P = prevocational, V = vocational registrar, C = continuing professional development)
- which is followed by the domain number (see *the five domains of general practice*) and dimensions
- followed by the curriculum item number.

For example:

DERLM1.2 identifies the second learning objective at the medical student level for the first domain (ie. communication) in the *Dermatology* statement.

## Curriculum statement by area

Statement chapter name	Code/abbreviation
<b>General curriculum statement chapters</b>	
Common training outcomes	CTO
Philosophy and foundation of general practice	PHI
<b>Specific curriculum statement chapters People and their populations</b>	
Aboriginal and Torres Strait Islander health	
Aged care	AGE
Children and young people's health	CYP
Disability	DIS
Doctors' health	DOC
Genetics	GEN
Men's health	MEN
Multicultural health	MCH
Population health and public health	POP
Rural general practice	RUR
Women's health	WOM
<b>Presentations</b>	
Acute serious illness and trauma	ACU
Chronic conditions	CHR
Dermatology	DER
Drug and alcohol medicine	DRU
Eye and ear medicine	EAE
Mental health	MHE
Musculoskeletal medicine	MSK
Occupational medicine	OCC
Oncology	ONC
Pain management	PAI
Palliative care	PAL
Sexual health	SEH
Sports medicine	SPO
<b>Processes of general practice</b>	
Critical thinking and research	CTR
Undifferentiated conditions	UND
E-health	EHE
Integrative medicine	INT
Multidisciplinary care	MDC
Practice management	PMA
Procedural skills	PRO
Quality and safety	QAS
Quality use of medicine	QUM
Teaching, mentoring and leadership in general practice	TML

# Context of Australian general practice

General practice has a core set of clinical characteristics and practices unique within medicine. These characteristics and practices are defined by the general practice curriculum developed and maintained by the RACGP and reflected in the standards set for clinical practice and the award of FRACGP.

General practice training is intended to equip graduates with core clinical skills and the ability to assess and address their learning needs over a professional lifetime. General practitioners encounter a wide range of clinical presentations according to social, demographic, cultural and epidemiological circumstances. In addition, GPs may need to develop, maintain and expand their skills as supervisors/teachers, mentors, researchers and leaders. These factors combine to form unique local practice characteristics, regional clinical trends and national characteristics.

## Definition of general practice

The term 'general practice' is not consistently used in international literature. The terms 'family medical practitioner', 'family physician' and 'family doctor' are also used to describe the primary care medical practitioner.

In Australia, The Royal Australian College of General Practitioners defines general practice as:

'General practice provides person centred, continuing, comprehensive and coordinated whole person healthcare to individuals and families in their communities'.<sup>1</sup>

General practice involves the ability to take responsible action on any medical problem the patient presents, whether or not it forms part of an ongoing patient-doctor relationship. In managing the patient, the clinician, called 'general practitioner' in Australia, may make appropriate referral to other doctors, healthcare professionals and community services.

## General practice as a specialty in Australia

In Australia, general practice is recognised as a specialty by a range of criteria, including by statute. Key events have led to the recognition of general practice as a specialty in Australia.

- In 1978, the National Specialist Qualification Advisory Committee stated that 'general practice is a specific and defined discipline in medicine'
- In 1989, general practice was established as a specialty with the introduction of the vocational register of recognised GPs<sup>2</sup>
- In 1999, the Australian Medical Council (AMC) developed a model to assess recognition of medical specialties and recognised general practice as one of the then, 17 medical specialties in Australia.<sup>3</sup>
- In 1989, changes led to the establishment of a separate listing of GPs who met the RACGP training, experience and assessment requirements:
  - Fellows of the RACGP are specialists as they have met the RACGP requirements for entry into the specialty of general practice
  - recognised GPs are specialists as they have met the RACGP requirements prior to the cut off date in 1995 for vocational registration
  - since 1996, Fellowship of the RACGP (FRACGP) is the minimum standard of entry into unsupervised general practice and the only route to recognised general practice.
- In 2003, the AMC, in line with its national processes for the review and accreditation of specialist education and training programs, accredited the RACGP's education and training program.<sup>4</sup>

# *Learning life of general practitioners*

Examining the steps to becoming a GP qualified for unsupervised practise in Australia helps define training needs at each stage of the path to becoming a competent GP.

Prior to entering general practice vocational training, medical practitioners will already have had many years of training by a range of individuals, organisations and institutions. A uniform general practice curriculum from the earliest stage of medical education helps support trainers. This forms a solid foundation for general practice training.

## **Learning life stages**

In Australia, the stages of the GP's learning life have been identified as:

- medical student
- prevocational doctor
- vocational general practice registrar
- continuing professional development.

Some students may enter this training path at different stages of the learning lifecycle. For example, an international medical graduate may enter at various points in the cycle depending on previous levels of qualifications.

Due to the comprehensive nature of general practice, some of these steps crossover with training pathways to other medical specialties and therefore have competing training priorities.

## **Medical student**

A medical student is defined as a student who is enrolled in a primary medical degree and will undertake a general practice placement.

Medical student teaching in Australia has undergone major change in recent times.

Consistent with the principle of the journey of general practice, medical student teaching now emphasises active learning, learning of key principles and preparation for lifelong learning.<sup>1</sup> In addition, the places where medical students are trained have also changed, with students spending more time in community health settings, doctors' private rooms and private hospitals, small urban and rural hospitals, as well as the more traditional tertiary teaching hospitals.

The content of medical courses has changed with the rise of evidence based medicine, the rapid increase in medical knowledge, new developments in areas such as molecular medicine and genetics, and the incorporation of issues driven by consumers and regulatory bodies.

Medical students have also changed. About half of Australia's medical schools only admit students who have a degree in another discipline, resulting in a more diverse age group than in the past. More than half of medical students are female, medical schools are committed to a higher proportion of rural and indigenous students, and the cultural diversity of students matches the changing ethnic groups within Australia.

In addition, some medical courses are undergraduate, while other courses are postgraduate. The term 'medical student' reflects the vocational nature of the medical course.

Around 30% of Australian medical graduates are currently entering general practice and this is the largest proportion of students entering a medical specialty in Australia.<sup>5</sup>

General practice teaching therefore has an obvious place in undergraduate medical curricula where the medical students are planning to become GPs.

However, these learning requirements need to intersect and overlap with the needs of students planning careers outside of general practice, or for the many students who have not yet decided on their future career paths.

## General practice: the foundation discipline

While there will be many undergraduates not planning a career in general practice, there will be many areas of curriculum overlap that will be of mutual benefit for all future graduates, regardless of their final vocation.

There are many skills that are common to all medical specialties, and these generalist skills are the core values of the medical specialty of general practice. General practice training can provide the basic foundation, or at least a significant proportion, of the professional skills required for other medical disciplines, including the patient-doctor relationship, advocacy and decision making and dealing with uncertainty and difficulty in complex situations.

Generalist skills involve a holistic approach to managing the health of individuals – a skill that should ideally cross all medical specialties. Rather than just dealing with diseases, GPs manage health within biomedical, psychological and social contexts based on firm epidemiological foundations. Medical management decisions are patient centred; made jointly between the doctor and the patient while understanding the personal significance of illness.

At the practice level, GPs are required to manage the complex micro-economy of a practice, deploying resources to maximum effect and to work closely with hospital colleagues, practice teams, community services and multidisciplinary teams. Doctors must build partnerships and advocate for patients and their profession, often in difficult and complex situations.

Many of the defined general practice skills, such as those described across the domains of general practice, are mutually necessary training requirements for medical specialties. These include elements in which general practice training departments have considerable expertise, such as communication skills, healthcare ethics and the behavioural sciences (*Figure 1*).

In addition, as general practice is the first point of contact for the majority of people seeking healthcare and often therefore the point of referral, knowledge of general practice is an essential part of the education of all multidisciplinary health team members.

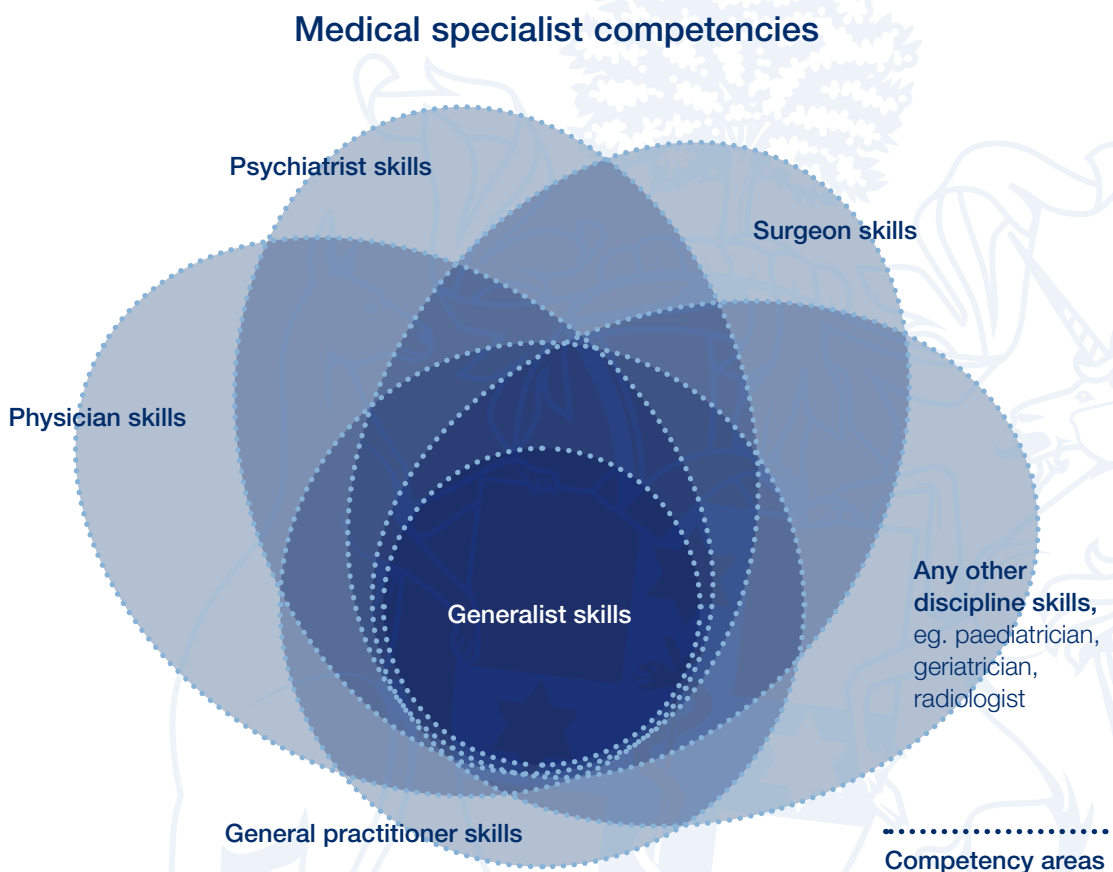


Figure 1. Generalist training common to all medical specialties sits within the discipline of general practice training and provides the foundation for many medical specialties

This helps to develop better links between primary care, hospitals and community based care, given that quality of healthcare is increasingly concerned with continuity, co-operation and communication between different health services as medical practice moves to a multidisciplinary approach.<sup>6</sup>

## The prevocational doctor

Prevocational doctors are defined as junior doctors who are undertaking supervised work in a hospital, but who have not yet enrolled in a specialty training program.

Junior doctors undertaking postgraduate work while working in hospitals may enter specialist training paths at various times. General practice education training needs to recognise the multiple priorities and demands that affect prevocational doctors, as some may have chosen a future career in areas other than general practice.

In Australia, the curriculum and learning needs of prevocational doctors are areas of much debate and work. The *Australian Curriculum Framework for Junior Doctors* developed by the Confederation of Postgraduate Medical Education Councils,<sup>6</sup> provides a common level of skills for junior doctors in Australia. Most of these skills sit well within the generalist skills required for general practice, although many junior doctors will start to acquire additional skills and competencies in preparation for entering other vocational training programs beyond those listed in the curriculum. This will usually involve self directed learning and mentoring as the prevocational doctor takes the step toward vocational training.

## The vocational doctor

Completion of vocational training and the FRACGP equip medical practitioners with the core competencies required for unsupervised practice in Australia. A vocational general practice registrar can also be in training for Fellowship in Advanced Rural General Practice (FARGP). (See the *Rural general practice* curriculum statement.)

For many GPs, the qualification of FRACGP or FARGP is only one more step in their learning life.

## Continuing professional development

After qualifying as a vocational GP, and as part of professional learning life requirements, all GPs need to ensure ongoing professional development and continuing quality assurance activities in order to maintain core general practice competencies.

As part of continuing professional development, many GPs also choose to become general practice educators and supervisors, or to participate in the ongoing development of general practice standards through the RACGP.

General practitioners may also need to develop skills beyond basic vocational requirements. For example, a rural GP may need to maintain a level of obstetric and anaesthetic skills not required by an inner city GP. There may be intercollegiate committees that regulate these activities, and GPs may need to participate in designated ongoing professional development programs. An Australian example is the joint consultative committees that work across medical colleges.<sup>7</sup>

In November 2008, the RACGP Council endorsed the creation of the National Faculty of Specific Interests (NFSI). This new faculty allows the RACGP to formally recognise those GPs with an additional interest and expertise in a specific area of clinical practice. The NFSI is charged with the role of conduit, allowing GPs with an interest in a specific area of general practice the ability to pursue their interest within the College rather than look outside the College for like-minded members and networking or educational opportunities.<sup>8</sup>

In all of these situations, GPs need to self direct their learning requirements and may need to comply with regulatory requirements to be eligible to provide services, such as medical imaging, or to be eligible for medical indemnity cover.

Other GPs may take further formal postgraduate training and the learning professional life of GPs needs to recognise the diversity of ongoing learning activities in which GPs participate.

## Principles of the lifelong learning of GPs

Over a GP's professional lifetime each level of learning builds upon the previous learning level and assumes that all previous requirements have been met.

In reality, the path is continuous rather than consisting of discrete steps. Most learning levels will overlap to some extent (*Figure 2*), so that:

- a medical student may have a special interest in women's health and decide to study beyond the undergraduate curriculum
- a first year prevocational doctor may have already decided to develop a special interest in public health, but has decided to train as a vocational GP on their way to their final goal and may already have acquired high level skills in their special interest area.

## Adult learning principles and concepts

The RACGP Curriculum for Australian General Practice 2011 is based on the following key adult learning educational concepts and principles that are applied across the GP learning life:

- needs focused training – directed toward meeting the healthcare needs and priorities of the Australian community
- learning as a continuum – integrates vocational training with undergraduate, postgraduate and continuing medical education
- lifelong learning – encourages a commitment to continuous improvement of knowledge and skills throughout a GP's learning life
- experiential learning – emphasises training as a supervised 'real world' clinical experience of consulting with patients who present with common and significant conditions, typical to general practice

### Lifelong learning and the GP professional lifecycle

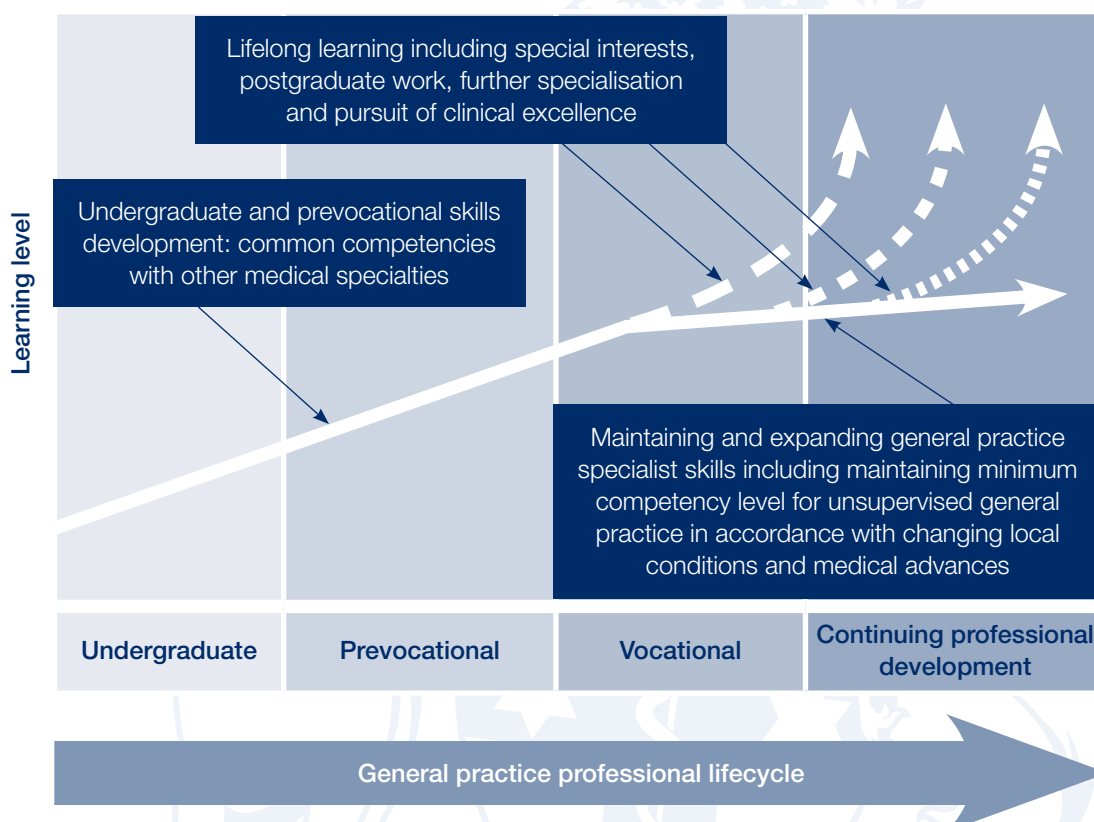


Figure 2. Each level of lifelong learning builds upon the previous level of knowledge

- purpose driven learning – clearly states purposes and curriculum requirements to enable learners to make informed choices about learning pathways
- integrated training – balances and integrates experiential, information based and reflective learning
- adult learning – uses models of learning based on recognition of different learning styles and needs
- self directed learning – expects adult learners to exercise significant autonomy in making choices about their learning
- feedback – requires high quality and regular feedback to learners on their performance as an integral and critical part of teaching and supervision
- assessment – regular assessment of learner achievement of curriculum learning objectives during and at the end of training to determine satisfactory completion of training requirements.

## GPs as mentors and teachers

The maintenance of high quality general practice education and training depends on the recruitment and training of medical educators in each generation of GPs.

The nature of this teaching varies from informal settings to strictly regulated training programs with summative examination processes.

In reality, each level is often involved in the education of those in earlier lifecycle stages. For example, a prevocational doctor may educate or mentor medical students, a third year junior doctor may teach procedural skills to a first year junior doctor, and a qualified GP may teach all levels of GPs.

A good clinician does not necessarily make a good teacher, and attention to the levels of training and teaching skills required at each level of the learning life helps to maintain and improve ongoing educational skills levels.

For example, as part of continuing professional development, GPs may consider their role in teaching medical students or general practice registrars and may need to examine their skill requirements.

## GPs as leaders

The increasing complexity of primary healthcare and the increased role of multidisciplinary patient care and incorporation of quality improvement measures at the practice level require GPs to acquire the skills necessary to be effective leaders.

General practitioners need to be able to set organisational values and strategic direction within a practice (which is different from management) that involves directing people and resources to achieve organisational goals. It also involves developing multidisciplinary team approaches to quality and safety within the practice.

The acquisition of leadership skills, closely related to the skills required for teaching and mentoring, need to be incorporated at all levels throughout the GP's learning life.

## GPs as researchers

'Primary care research is the missing link in the development of high quality, evidence based healthcare for populations'.<sup>9</sup>

General practice research not only improves patient care and enables teachers to contribute to their discipline, but also stimulates intellectual rigor and critical thinking, which is identified in this curriculum as a core competency.

The rise of evidence based medicine and the concurrent need for equipping students with appropriate analytical skills means that skills that were normally only part of the domain of researchers are now commonplace among medical practitioners. In addition, the increasing use of clinical audits as a means to quality improvement in the general practice setting requires the application of basic research skills.

## Planning and accountability

A uniform general practice curriculum across the professional learning life provides a transparent process to ensure that, in addition to professional requirements, the community expectations and obligations of GPs are met.

Defining requirements at each level provides a common ground for negotiating medical student curricula with other medical specialties to achieve cross-discipline curricular consistency. Such a process is likely to be iterative as knowledge and fields evolve. However, an explicit process will clarify mutual learning objectives, plan skills development and ultimately ensure that patient care needs are met.






An explicit lifecycle learning approach also provides an open, transparent and robust process by which governments, regulators and other general practice stakeholders and community groups can influence the curriculum process across the entire field of medical education to ensure both professional and societal accountability.

## *The five domains of general practice*

The five domains of general practice represent the critical areas of knowledge, skills and attitudes necessary for competent unsupervised general practice. They are relevant to every general patient consultation.

*The RACGP Curriculum for Australian General Practice 2011* bases lifelong teaching and learning on these domains.

### The five domains of general practice

-  **Domain 1** – Communication skills and the patient-doctor relationship (eg. communication skills, patient centredness, health promotion, whole person care)
-  **Domain 2** – Applied professional knowledge and skills (eg. physical examination and procedural skills, medical conditions, decision making)
-  **Domain 3** – Population health and the context of general practice (eg. epidemiology, public health, prevention, family influence on health, resources)
-  **Domain 4** – Professional and ethical role (eg. duty of care, standards, self appraisal, teacher role, research, self care, networks)
-  **Domain 5** – Organisational and legal dimensions (eg. information technology, records, reporting, confidentiality, practice management).

The five domains of general practice provide a comprehensive, robust framework for ensuring that the key skill areas of general practice are included in education and training.

# *The star of general practice and development of a new curriculum framework*

Combining the domains of general practice with lifelong learning provides a powerful conceptual framework for positioning the 2011 curriculum in the Australian clinical context in which the knowledge and skills are applied. This can be represented as the 'star of general practice' (Figure 3).

The framework enables educators to train GPs across the diverse and wide range of clinical presentations, which vary according to social, demographic, cultural and epidemiological circumstances.

Even though local practice characteristics, regional clinical trends or national characteristics may vary, this model provides a common ground for the essential discipline of general practice knowledge across the learning life cycle and domains of general practice.

## Star of general practice

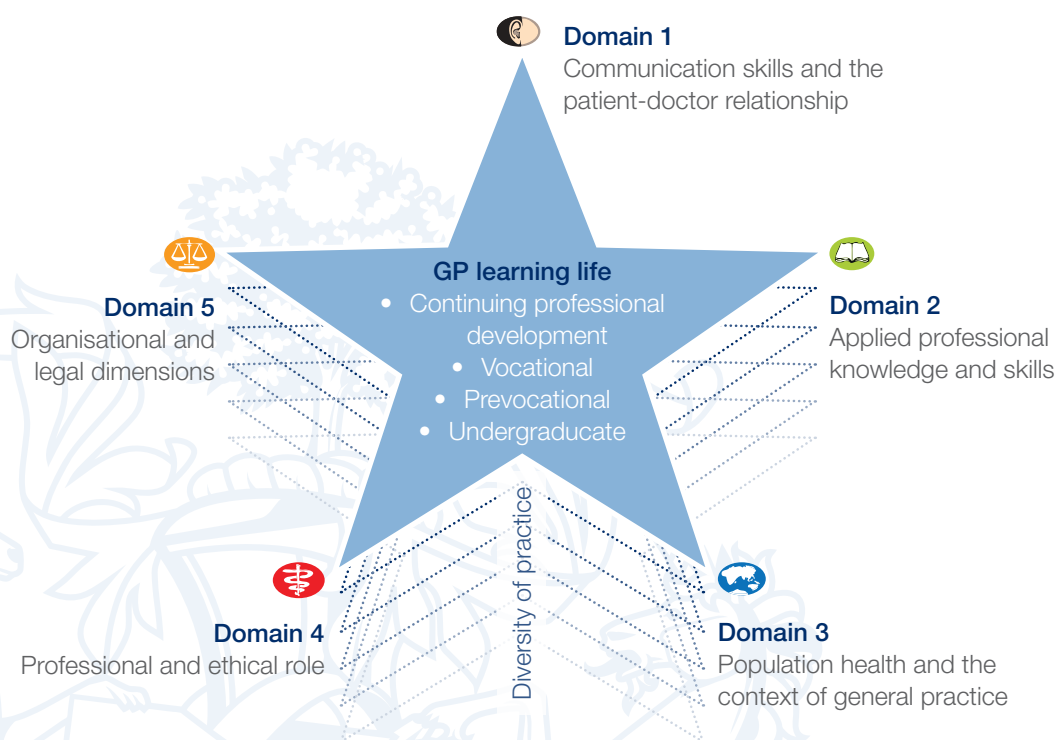
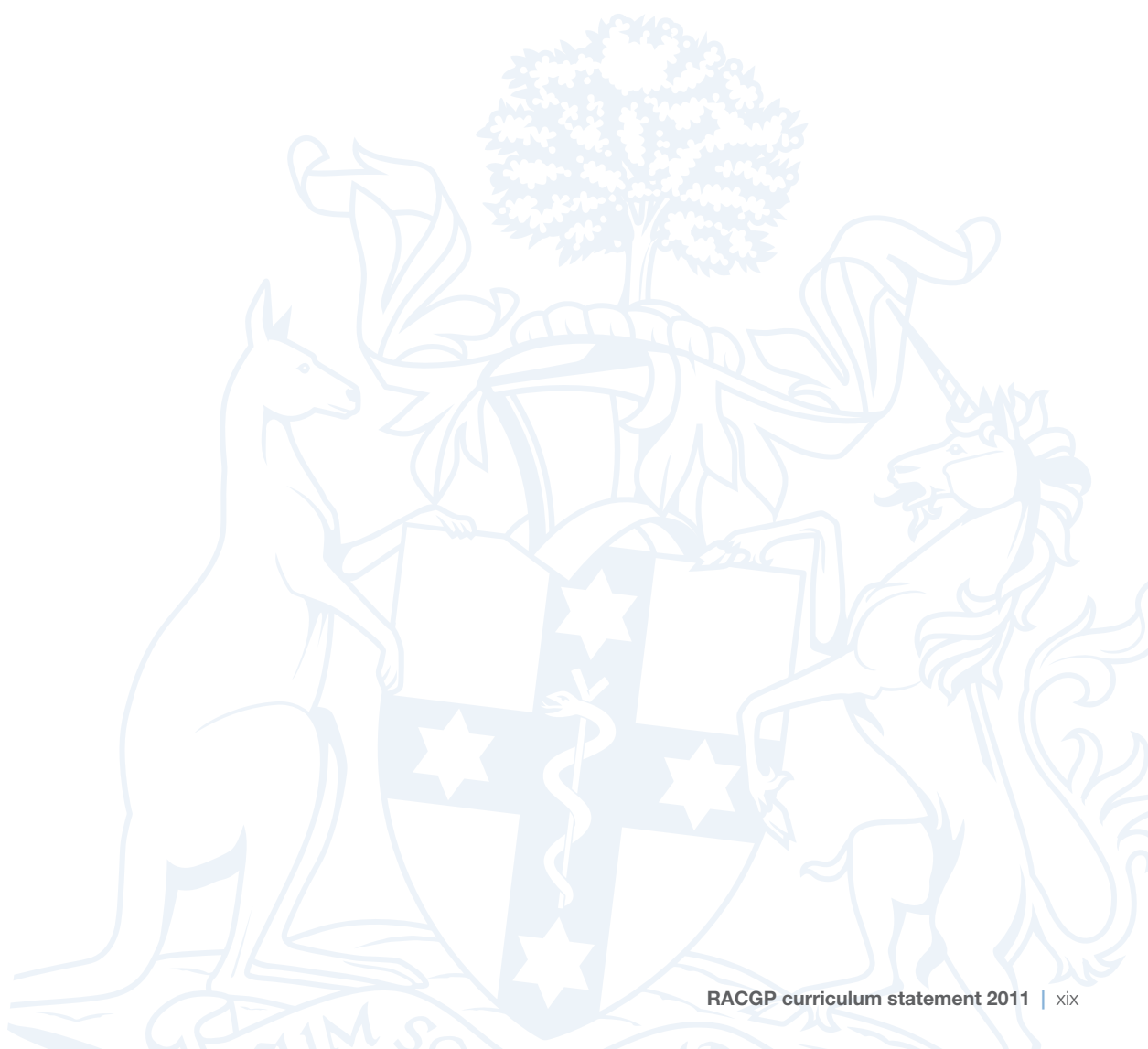


Figure 3. The 'star of general practice' provides a model of the discipline of general practice that meets the training requirements across the GP learning life

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# Curriculum feedback

Curriculum renewal is always ongoing due to the rapid pace of change of medicine and the general practice environment, and continued feedback is encouraged and welcomed via this page.

Feedback is welcome from all individuals and organisations to ensure that the Australian public has the opportunity to help shape general practice to meet the needs of the Australian community.

## How to submit your comments on The RACGP Curriculum for Australian General Practice 2011

You can contact the curriculum renewal team via email on [curriculum@racgp.org.au](mailto:curriculum@racgp.org.au) or post your feedback to:

RACGP Curriculum Renewal  
College House  
1 Palmerston Crescent  
South Melbourne, Victoria 3205

Please complete the form below to submit your comment

### Your details

First name

Surname

Email

Organisation

Occupation

Telephone

RACGP no. (if applicable)



The Royal Australian  
College of General  
Practitioners

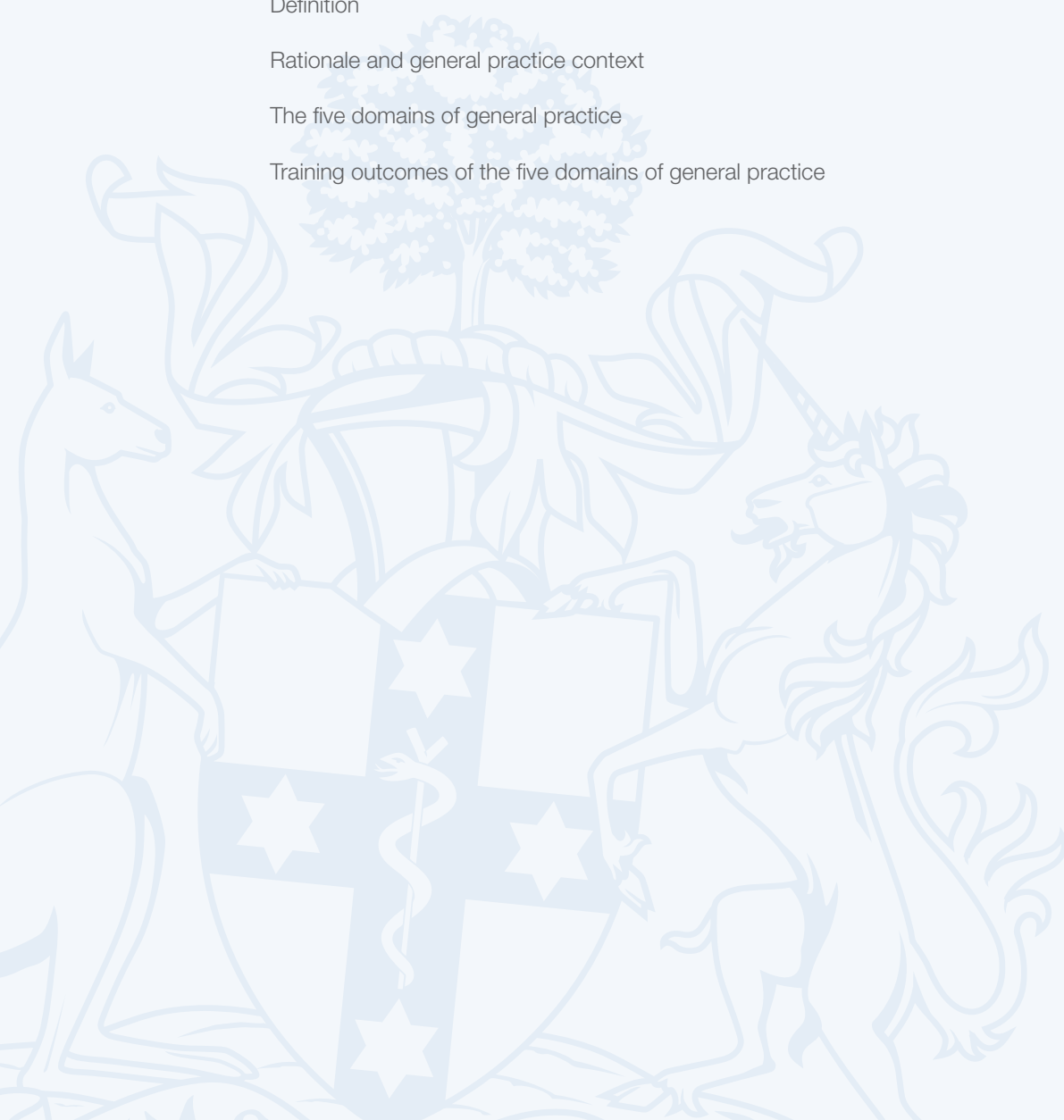
# *The RACGP Curriculum for Australian General Practice 2011*

## *Common training outcomes*

### **Contents**

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Definition	23
Rationale and general practice context	24
The five domains of general practice	26
Training outcomes of the five domains of general practice	28



**The Royal Australian College of General Practitioners  
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## Definition

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The Royal Australian College of General Practitioners Curriculum for Australian General Practice defines the common training outcomes for general practice as those ‘training outcomes that are relevant to consulting with all patients in unsupervised general practice’. They outline the minimum skill sets required for competent practice as a general practitioner.

This curriculum statement provides the required common training outcomes for general practice and was first developed by the RACGP for its vocational training registrars in 1999. It was subsequently updated for The Royal Australian College of General Practitioners Curriculum for General Practice (2007).

The name ‘common learning objectives’ has been changed to ‘common training outcomes’, although the actual training requirements of this section have not changed.

## Rationale and general practice context

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The RACGP developed the common training outcomes after taking into account:

- what GPs need to know (the domains of general practice)
- why most people seek the services of a GP (common patient presentations)
- the health needs and priorities of Australia's population.

### Common patient presentations

General practice primarily involves providing advice to individual patients in the diagnosis, treatment and management of medical conditions.

General practitioners manage the majority of medical presentations in the community. The Curriculum for Australian General Practice reflects the type of patient presentations that come to the attention of GPs and therefore highlight:

- problems which significantly contribute to morbidity and mortality
- common presentations which exemplify general practice
- presentations requiring special skills
- health problems which present differently in different population groups
- presentations with a public health significance
- health problems that have been shown to be preventable.

### Key educational principles and concepts

This curriculum for Australian General Practice is based on the following key educational concepts and principles:

#### **Needs focused training**

Directed toward meeting the healthcare needs and priorities of the Australian community.

#### **Learning as a continuum**

Integrates vocational training with undergraduate, postgraduate and continuing medical education.

#### **Lifelong learning**

Encourages a commitment to continuous improvement of knowledge and skills throughout the GP's learning life.

#### **Experiential learning**

Emphasises training as a supervised 'real world' clinical experience of consulting with patients presenting with the common and significant conditions that exemplify general practice.

#### **Purpose driven learning**

Clearly states purposes and curriculum requirements to enable learners to make informed choices about learning pathways.

#### **Integrated training**

Balances and integrates experiential, information based and reflective learning.

**Adult learning**

Uses models of learning based on recognition of different learning styles and needs.

**Self directed learning**

Expects adult learners to exercise significant autonomy in making choices about their learning.

**Feedback**

Requires high quality and regular feedback to learners on their performance as an integral and critical part of teaching and supervision.

**Assessment**

Regular assessment of learner achievement of curriculum learning objectives during and at the end of training to determine satisfactory completion of training requirements.

**Related curriculum areas**

Refer also to the curriculum section:

*Learning life of general practitioners* for further information on educational principles.

## The five domains of general practice

---

The five domains of general practice represent the critical areas of knowledge, skills and attitudes necessary for competent unsupervised general practice. They are relevant to every patient interaction. Teaching and learning is based on the acquisition of these key knowledge, skills and attitudes.

This section relates the five domains of general practice to the common training outcomes.

### Domain 1. Communication skills and the patient-doctor relationship

Good communication skills enable a GP to develop a relationship with patients in order to understand both the illness and the patient's experience of that illness, and to move freely between clinical problem solving and the patient's experience of the problem.

Communication skills and the patient-doctor relationship includes the following areas:

- communication skills
- patient centredness
- communicating health promotion
- whole person care.

### Domain 2. Applied professional knowledge and skills

The application of professional knowledge and skills requires a comprehensive, patient centred approach. This applies not only to health and disease, but also to the individual's experience of illness in terms of their culture, family and community. This approach includes analysis of the appropriateness and cost effectiveness of all clinical interactions.

Applied professional knowledge and skills includes the following areas:

- physical examination and procedural skills
- medical conditions
- decision making.

### Domain 3. Population health and the context of general practice

Population health, in the context of general practice, is an essential component of primary healthcare. The GP has an evolving role with the potential to create change at the individual patient, practice, and community levels within the healthcare system. This requires knowledge of the sociopolitical, economic, geographical, cultural and family influences on the health of patient groups and their communities.

Population health and the context of general practice includes the following areas:

- epidemiology
- public health
- prevention
- family influence on health
- resources.

## Domain 4. Professional and ethical role

The GP's professional and ethical role relates to their behaviour with respect to patients, colleagues and the community. Professional ethics are based on belief systems of the profession and the community.

Professional and ethical role includes the following areas:

- duty of care
- standards
- self appraisal
- teacher role
- research
- self care
- networks.

## Domain 5. Organisational and legal dimensions

Organisational and legal dimensions includes the following areas:

- information technology/e-health
- records
- reporting
- confidentiality
- practice management.

# Training outcomes of the five domains of general practice

---

## 1. Communication skills and the patient-doctor relationship

- CTOT1.1 General practitioners who are competent in this domain will be able to:
- CTOT1.1.1 critically appreciate the nature of the relationship between patient and doctor and its therapeutic potential
  - CTOT1.1.2 understand of different consultation models
  - CTOT1.1.3 use a patient centred approach
  - CTOT1.1.4 have the communication skills and attitudes needed to foster effective whole person care
  - CTOT1.1.5 have the skills to undertake effective individualistic and opportunistic health education and promotion.
- CTOT1.2 The minimum knowledge, skills and attitudes in this domain that GPs need to demonstrate are how to:
- CTOT1.2.1 establish rapport and be empathic with patients
  - CTOT1.2.2 develop good listening and language skills appropriate to the patient
  - CTOT1.2.3 adopt appropriate verbal and nonverbal communication styles for different situations (eg. emotional states, state of health, disadvantage, cultural background)
  - CTOT1.2.4 elicit the patient's issues, problems and concerns
  - CTOT1.2.5 engender confidence and trust (and advocate on the patient's behalf where appropriate)
  - CTOT1.2.6 use body language and touch in an appropriate manner to establish trust in a therapeutic relationship
  - CTOT1.2.7 find common ground with patients about their problems and expectations
  - CTOT1.2.8 negotiate an effective management plan and agree on respective responsibilities and limits with the patient and their family
  - CTOT1.2.9 communicate effectively and appropriately with significant others (eg. partner and family)
  - CTOT1.2.10 recognise opportunities for health promotion and education and respond appropriately to increase the patient's capacity for self care
  - CTOT1.2.11 confirm the patient's understanding of the problem, management, advice and follow up.

## 2. Applied professional knowledge and skills

- CTOT2.1 General practitioners who are competent in this domain will need to demonstrate:
- CTOT2.1.1 a knowledge of significant medical conditions and approaches to undifferentiated problems
  - CTOT2.1.2 skills in information gathering, physical examination, the undertaking of procedures and clinical decision making
  - CTOT2.1.3 a critical appreciation of the need for continuity and integration of care, cost effective investigations, rational prescribing and the need to continually undertake critical self appraisal.
- CTOT2.2 The minimum knowledge, skills and attitudes in this domain that GPs need to demonstrate are how to:

CTOT2.2.1	take a history and perform a physical examination relevant to presenting problems
CTOT2.2.2	develop a working diagnosis from their knowledge and experience and the information gathered
CTOT2.2.3	critically use investigations and interpret the results to refine the working diagnosis
CTOT2.2.4	recognise and manage the significantly ill patient
CTOT2.2.5	consider the possibility of serious illness inherent in many common presentations
CTOT2.2.6	competently manage common problems (including undifferentiated illness)
CTOT2.2.7	negotiate, prioritise and implement management plans
CTOT2.2.8	prescribe safely and cost effectively from an informed knowledge base
CTOT2.2.9	use hospital and community based expertise, resources and networks effectively
CTOT2.2.10	make valid and timely decisions about referral and follow up
CTOT2.2.11	develop and maintain essential procedural skills
CTOT2.2.12	recognise their own abilities and limitations, responding appropriately
CTOT2.2.13	accept and manage uncertainty
CTOT2.2.14	be critical and discriminating in the use of information from a range of sources
CTOT2.2.15	consistently apply universal precautions principles.

### 3. Population health and the context of general practice

CTOT3.1	General practitioners who are competent in this domain will need to:
CTOT3.1.1	have an understanding of demographics, epidemiology, public health problems and health needs of special groups
CTOT3.1.2	be aware of the patterns and prevalence of disease and be able to participate in population based preventive strategies
CTOT3.1.3	have a critical appreciation of the impact on the health of the patient of their sociopolitical, economic, work, spiritual and cultural background and needs, and their relationships with family and significant others
CTOT3.1.4	possess skills in advocacy and in using community resources
CTOT3.1.5	appreciate the importance of a public health perspective in general practice.
CTOT3.2	The minimum knowledge, skills and attitudes in this domain, which GPs need to demonstrate, are how to:
CTOT3.2.1	elicit and take into account a patient's sociopolitical, economic, work, spiritual, linguistic and cultural background and needs, as well as their relationships with family and significant others in relation to their health
CTOT3.2.2	understand and respond to the special needs and characteristics of their practice population including disease prevention and health promotion screening and recall systems, and access and equity issues

- CTOT3.2.3 use a working knowledge of, and be involved in assisting the health of the community locally, regionally and nationally. This includes participating in community based prevention and education strategies and accessing available health services such as networking with other GPs, GP organisations and healthcare providers, involvement in the public health system and strategies (eg. notifiable diseases and environmental issues)
- CTOT3.2.4 understand and utilise the Australian healthcare system (including its funding planning, services policies and community resources).

## 4. Professional and ethical role

- CTOT4.1 General practitioners who are competent in this domain will need to demonstrate:
- CTOT4.1.1 the special duty of care that arises when a patient-doctor relationship is established and the patient's needs involve the risk of injury. Doctors have a duty to exercise due care and skill to avoid any such injury and will become legally liable for the consequences of their own negligence
  - CTOT4.1.2 reflective skills and self appraisal
  - CTOT4.1.3 maintenance of professional standards, which imply that all doctors have an obligation to keep abreast of, and be informed about technical advances, new techniques and new therapies appropriate to their field of medicine (or field in which they profess to have special skills)
  - CTOT4.1.4 special duty of care at all times
  - CTOT4.1.5 professional standards of practice according to contemporary ethical principles
  - CTOT4.1.6 skills in reflection and professional self appraisal and being committed to lifelong learning and continuous professional improvement
  - CTOT4.1.7 skills that fulfil their role as teacher, leader and change agent
  - CTOT4.1.8 an understanding of research, evaluation and audit skills
  - CTOT4.1.9 use of professional networks and maintenance of their own wellbeing and that of their families.
- CTOT4.2 The minimum knowledge, skills and attitudes in this domain that the general practice registrar needs to demonstrate are:
- CTOT4.2.1 special duty of care:
    - responsibility for the optimal care of patients (including acting on patient cues, respecting patient-doctor boundaries and confidentiality, recognising own limitations, ensuring appropriate reporting and follow up, and undertaking advocacy as appropriate)
    - respect for a patient's culture and values, and an awareness of how these have an impact on the therapeutic relationship
    - understand the rights of patients to access competent, compassionate care, to be fully informed and their right to self determination
  - CTOT4.2.2 reflective skills and self appraisal:
    - the capacity for self awareness, reflection and self appraisal
    - the skills of lifelong learning
    - basic skills in clinical audit, critical appraisal and critical incident analysis, and professional development
    - networks for personal and clinical support
    - time management and coping skills sufficient to maintain care of self and family

- CTOT4.2.3 maintenance of professional standards:
- achieve and maintain professionally defined clinical practice standards
  - adhere to the professional codes of ethics
  - contribute to the development of general practice by gaining skills in areas such as teaching, research and evaluation.

## 5. Organisational and legal dimensions

- CTOT5.1 General practitioners who are competent in this domain will need to:
- CTOT5.1.1 ensure adequate arrangements are made for the availability and accessibility of care, and to ensure safety netting, screening and recall systems are in place
  - CTOT5.1.2 have a critical appreciation of patient and practice information technology and management requirements, medical records and legal responsibilities, and reporting, certification and confidentiality requirements
  - CTOT5.1.3 understand effective practice management principles and processes.
- CTOT5.2 The minimum knowledge, skills and attitudes that GPs need to demonstrate are:
- CTOT5.2.1 use of personal, organisational and time management skills in practice
  - CTOT5.2.2 accurate and legible recordings of consultations and referrals to enable continuity of care by GPs and other colleagues
  - CTOT5.2.3 use and evaluation of practice management skills relating to patient access guidelines, staff management, teamwork, office policies and procedures, and financial and resource management
  - CTOT5.2.4 manage information and data systems relating to clinical standards, guidelines and protocols; medical records; information technology; communication and transfer of patient related information; screening, recall and related systems; and access and confidentiality
  - CTOT5.2.5 incorporate medicolegal knowledge and responsibilities relating to certification, confidentiality, legal report writing, prescribing; informed consent, duty of care, and litigation
  - CTOT5.2.6 work within statutory and regulatory requirements
  - CTOT5.2.7 meet acceptable practice standards.





# *Philosophy and foundation of general practice*

## Contents

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Definition	35
Curriculum in practice	35
Rationale and general practice context	36
Training outcomes of the five domains of general practice	40
Learning objectives across the GP professional life	42
<i>Medical student</i>	42
<i>Prevocational doctor</i>	44
<i>Vocational registrar</i>	46
<i>Continuing professional development</i>	48
References	49

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## Definition

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The foundation of general practice includes the philosophy, concepts and principles that define the roles of general practitioners and the discipline of general practice.

This foundation defines:

- what is involved in being a GP
- how this role is different from other disciplines within medicine
- the role of general practice in the lives of individual patients, their personal context, their communities, and the health system.

For medical students and prevocational doctors, an understanding of this foundation will improve understanding of the place and significance of general practice in their working life.

For vocational trainees, this foundation will provide a framework for building a detailed and comprehensive understanding of their chosen profession of general practice.

For established GPs, this foundation provides an external reference as a basis for reflection on the knowledge, skills and attitudes developed in training and from clinical experience.

The philosophies, concepts and principles of general practice permeate all aspects of general practice. The learning objectives of this statement should therefore be borne in mind in relation to all the priority learning areas.

## Curriculum in practice

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The following case illustrates how the philosophy and foundation of general practice curriculum applies to general practice:

- As an experienced GP supervisor you have been invited to address the graduating year of the University Centre of Excellence. Positioned on either side of you are professors whose names you recognise from journal articles as international experts. Your topic is the changing role of general practice and you see this as an opportunity to inspire the next generation. As you wait your turn to speak, you reflect on the highs and lows of 25 plus years of practice. You are well aware of the changes that have already taken place, yet cannot help but think that the core elements of general practice have remained the same. Listening to one of the other specialists talking about exciting new technology, you decide to focus your talk, as you have your career, on the care of each person who walks through your door. 'Let me tell you the story of Mikaela ...'

## Rationale and general practice context

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General practice is the primary focus of the Australian healthcare system.

General practitioners provide ongoing patient centred healthcare for all members of the community based on an understanding of health and illness as a uniquely personal experience, shaped by past experience, cultural, social and contextual dimensions.

General practice manages patient health and illnesses grounded in knowledge from biomedical, psychosocial, intrapersonal and interpersonal perspectives.

At both a systemic and consultation level, general practice is the interface between medicine and the community, science and humanity, evidence and creativity.

Australian general practice in the 21st century is the continuation of a millennium-long tradition of caring for the sick, and the central place of general practice will continue to evolve as part of a dynamic, diverse society, which it will reflect and influence.

The discipline of general practice has evolved through historical, cultural, social, political and contextual influences, but certain core characteristics relating to the relationship between patient and doctor, and doctor and community, have remained immutable over time. These include:

- the patient as the centre of concern
- the patient-doctor relationship as the basis of the therapeutic process
- the distinctive problem solving skills of GPs
- primary care management
- a holistic perspective to care
- comprehensive scope
- a community based context.

### The patient-centred approach to general practice care

General practitioners have the breadth and depth of knowledge of disease as covered by this curriculum, but integrate this knowledge with an understanding that the presence or absence of disease does not necessarily correlate with a health-to-illness continuum, being patient focused, rather than disease focused.

*‘... the kind of commitment I am speaking of implies that the physician will “stay with” a person whatever his problem may be, and he will do so because his commitment is to people more than to a body of knowledge or a branch of technology. To such a physician, problems become interesting and important not only for their own sake but because they are Mr Smith’s or Mrs Jones’s problem. Very often in such relations there is not even a very clear distinction between a medical problem and a nonmedical one. The patient defines the problem.’<sup>1</sup>*

### Managing complexity and uncertainty in general practice

The relationship GPs have with their patients, together with the importance of the context in which patients and their doctors live, mean that GPs need to be skilled in managing complexity and uncertainty.

The challenge of managing complexity and uncertainty is also increased by the natural epidemiology of disease in the community and changes in medical care technology.

Issues contributing to complexity and uncertainty in these areas include:

- early presentation of disease
- relatively infrequent occurrence of serious illness
- recognition, integration and management of multiple issues, often in a single consultation, but also over time
- influence of comorbidities on each individual health problem
- ongoing management of the increasing prevalence of chronic illness in the community
- ability to manage complex illness based on advanced and developing technologies
- constantly evolving boundaries between other healthcare providers and general practice based care, including issues of access and affordability, which may be practice and/or location specific
- understanding of the structure and the dynamics of the community
- collaboration with patients in drawing on and developing their self care skills.

## General practitioners as patient advocates in complex health systems

In contrast to specialist practice, in which patients are selected to match the service provided, GPs need to be flexible and able to draw on an extensive range of knowledge and skills in meeting the health needs of individual patients, both in the short term and over a long professional relationship. General practitioners incorporate the expertise of other healthcare providers as appropriate, and this includes the essential role of acting as patient guide and advocate in an increasingly fragmented healthcare system.

## Good general practice primary care improves the health of populations

Health systems firmly based on primary healthcare have been shown to achieve better health outcomes, improve health equality and be cost effective.<sup>2</sup>

## Integrating the foundation skills of general practice into a comprehensive care approach – key principles

The foundations of general practice need to be understood in the context of a complex, integrated totality that reflects the whole patient, their environment, and how these interact with each other.

The following key principles are the specific skills necessary for quality general practice care.

The quotes after the key foundation principle expresses this concept as a GP might describe them, followed by the key skills required to demonstrate these principles.

While the skills are listed individually, every element needs to be integrated into the whole of general practice to meet the aim of comprehensive care.

### The patient is the centre of concern

*'It is important to know my patients. I am more concerned about patients as individuals than about the disease. I take my patients' beliefs, circumstances and concerns into account when deciding what to prescribe or when and where to refer them.'*

This principle requires GPs to:

- demonstrate respect for patient autonomy
- work in partnership with the patient as determined by the needs of the patient
- negotiate management plans in terms of the patient's preferences and priorities.

### **The patient-doctor relationship is the basis of the therapeutic process**

*'It is important that patients can trust their GP. Sometimes more good is done by just listening.'*

This principle requires GPs to:

- develop communication skills to underpin effective diagnosis and management (eg. listening, reassuring, explaining, interpreting)
- develop effective communication skills to build and maintain a therapeutic relationship
- develop more specific counselling skills in different situations
- foster continuity of care as determined by the needs of the patient
- develop self awareness and boundaries.

### **Distinctive problem solving skills**

*'I know the community. I know the "horses and zebras". I often need to juggle several problems at a time. General practice is an art and a science.'*

This principle requires GPs to:

- relate the diagnostic process to the community context (eg. disease prevalence)
- recognise serious and urgent problems
- use time as a tool
- tolerate uncertainty
- collaborate with patients on acceptable management plans
- integrate comorbidities into management decisions
- use investigations and technology appropriately
- integrate scientific evidence and other relevant factors toward a solution
- move from one mode or role to another (eg. diagnostician, counsellor) as required by the problem at hand or by the patient's needs
- engage in reflective practice.

### **Primary care management**

*'I am the first port-of-call. I have colleagues I can call on when I need to and I know the available services in the community.'*

This principle requires GPs to:

- deal with unselected and undifferentiated presentations
- triage appropriately
- work in teams
- integrate the expertise of other healthcare providers
- practise ongoing management of patients with chronic health problems.

### **Holistic perspectives**

*'I know this patient's background and it really influences how he is suffering now. I also know whether he can afford treatment.'*

This principle requires GPs to:

- take into account social, psychological, cultural and existential dimensions
- be integrative rather than reductionist.

### Comprehensive scope

*'You never know who walks through the door. General practice care is more than dealing with the presenting complaint. At times it's difficult to know where to start.'*

This principle requires GPs to:

- recognise that the range of patients are not limited by age, gender, culture or health problem
- diagnose and manage disease at any chronological stage in the process including:
  - health promotion
  - prevention
  - case finding
  - acute presentations
  - chronic illness
  - palliative care
- know how to diagnose and manage a broad range of health conditions across multiple systems
- diagnose and manage multiple morbidities or concerns in the one patient.

### Community based context

*'I meet patients where they live and take our community into account when planning their care.'*

This principle requires GPs to:

- be limited only by what may be managed in the particular community (not just primary care)
- respond to the needs of community
- adapt to the political context
- mediate between medicine and community
- understand the private practice context
- work effectively within the healthcare system (eg. legal requirements for prescribing and legislative regulations).

### Related curriculum areas

Refer also to the curriculum statement:

- *Common training outcomes.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- PHILT1.1 Demonstrate respect for patient autonomy.
- PHILT1.2 Work in partnership with the patient as determined by the needs of the patient.
- PHILT1.3 Negotiate patient centred management plans that consider the patient's preference of treatment and priority of treatments.
- PHILT1.4 Use communication skills to underpin effective diagnosis and management of the patient (eg. listening, reassuring, explaining, interpreting).
- PHILT1.5 Use communication skills to build and maintain a therapeutic relationship between patient and doctor.
- PHILT1.6 Apply specific counselling skills in different situations.
- PHILT1.7 Foster continuity of care as determined by the needs of the patient.
- PHILT1.8 Move from one mode to another (diagnostician, counsellor) as required by the problem at hand or the patient's needs.

## 2. Applied professional knowledge and skills

- PHILT2.1 Relate the diagnostic process to the community context when problem solving.
- PHILT2.2 Recognise serious and urgent problems.
- PHILT2.3 Use problem solving skills to collaborate with patients on acceptable management plans.
- PHILT2.4 Integrate comorbidities when problem solving.
- PHILT2.5 Use investigations and technology appropriately when problem solving.
- PHILT2.6 Integrate scientific evidence and other relevant factors when problem solving.
- PHILT2.7 Manage unselected and undifferentiated presentations.
- PHILT2.8 Manage patients with chronic health problems.
- PHILT2.9 Have a holistic perspective that is integrative rather than reductionist.
- PHILT2.10 Be able to diagnose and manage a broad range of health conditions across multiple systems.

## 3. Population health and the context of general practice

- PHILT3.1 Have a holistic perspective, taking into account the patient's social, psychological, cultural and existential dimensions.
- PHILT3.2 Treat a wide range of patients not limited by age, gender, ethnicity or health problem.
- PHILT3.3 Be able to diagnose and manage disease at any chronological stage in the process, including health promotion, prevention, case finding, acute presentations, chronic illness and palliative care.
- PHILT3.4 Be limited only by what may be managed in the particular community (not just primary care).
- PHILT3.5 Respond to the needs of the community.
- PHILT3.6 Adapt to political priorities.
- PHILT3.7 Mediate between medicine and community.

## 4. Professional and ethical role

- PHILT4.1 Tolerate uncertainty when problem solving.
- PHILT4.2 Have a capacity for self awareness and recognise boundaries in the patient-doctor relationship.
- PHILT4.3 Practise reflective thinking when problem solving.

## 5. Organisation and legal dimensions

- PHILT5.1 Use time as a tool when problem solving.
- PHILT5.2 Triage appropriately when working in teams or integrating the expertise of other healthcare providers.
- PHILT5.3 Work effectively within the healthcare system and know the rules for procedures (eg. prescribing).
- PHILT5.4 Understand the private practice context.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- PHILM1.1 Describe the role of respect for patient autonomy in patient-doctor relationships when communicating with patients, and differences between hospital and primary care settings.
- PHILM1.2 Describe the importance of working in partnership with patients, including negotiating patient centred management plans as determined by patient need, preferences and priorities, and differences between hospital and primary care settings.
- PHILM1.3 Demonstrate the basic communication skills required to underpin effective diagnosis and management of the patient (listening, reassuring, explaining, interpreting) and fostering whole patient care, and describe differences in the hospital and primary care setting.
- PHILM1.4 Describe the need to adapt counselling skills to the needs of different situations.
- PHILM1.5 Describe the basis of continuity of patient care based on patient determined needs.
- PHILM1.6 Outline the various roles of the clinician according to patient needs (eg. diagnostician, counsellor).

### 2. Applied professional knowledge and skills

- PHILM2.1 Outline how to use problem solving skills to collaborate with patients on acceptable management plans.
- PHILM2.2 Describe the skills required to recognise serious and urgent problems.
- PHILM2.3 Outline the integration of comorbidities when problem solving.
- PHILM2.4 Describe the appropriate role of investigations and technology in problem solving.
- PHILM2.5 Outline how to integrate scientific evidence and other relevant factors when problem solving.
- PHILM2.6 Outline how to deal with unselected and undifferentiated presentations.
- PHILM2.7 Outline the management of patients with chronic health problems.
- PHILM2.8 Describe the differences between an integrative and a reductionist holistic perspective.
- PHILM2.9 Outline the skills required to diagnose and manage a broad range of health conditions across multiple systems.

### 3. Population health and the context of general practice

- PHILM3.1 Outline how diagnostic processes relate to community context (eg. disease prevalence).
- PHILM3.2 Describe a holistic perspective of primary healthcare that takes into account social, psychological, cultural and existential dimensions.
- PHILM3.3 Outline issues involved in treating a range of patients not limited by age, gender, ethnicity or health problem.

PHILM3.4 Outline the skills required to diagnose and manage disease at any chronological lifecycle stage, including health promotion, prevention, case finding, acute presentations, chronic illness and palliative care.

PHILM3.5 Describe how doctors can be responsive to community health needs.

#### 4. Professional and ethical role

PHILM4.1 Outline how to manage uncertainty when problem solving in patient care settings.

PHILM4.2 Describe the role of capacity for self awareness and recognition of boundaries in the patient-doctor relationship.

PHILM4.3 Outline processes for reflective practice when problem solving.

#### 5. Organisational and legal dimensions

PHILM5.1 Outline appropriate triage processes when working in teams or integrating the expertise of other healthcare providers.

PHILM5.2 Outline the structural elements of the health system that impact on clinical practice (eg. regulations for prescribing, other relevant medical legislation).

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- PHILP1.1 Demonstrate respect for patient autonomy in patient-doctor communications with patients in the hospital setting.
- PHILP1.2 Demonstrate the ability to work in partnership with patients, including negotiating patient centred management plans as determined by patient need, preferences and priorities in the hospital setting.
- PHILP1.3 Demonstrate effective communication skills required to underpin effective diagnosis and management of the patient (listening, reassuring, explaining, interpreting) and fostering whole patient care in the hospital setting.
- PHILP1.4 Demonstrate the ability to adapt counselling skills to different situations.
- PHILP1.5 Demonstrate continuity of patient care based on patient determined needs in the hospital setting.
- PHILP1.6 Demonstrate the ability to move between various roles of the clinician according to patient needs (eg. diagnostician, counsellor) in the hospital setting.

### 2. Applied professional knowledge and skills

- PHILP2.1 Demonstrate the ability to recognise serious and urgent problems in the hospital setting.
- PHILP2.2 Demonstrate how to use problem solving skills to collaborate with patients on acceptable management plans in the hospital setting.
- PHILP2.3 Demonstrate the integration of comorbidities when problem solving in the hospital setting.
- PHILP2.4 Demonstrate the appropriate use of investigations and technology in problem solving in the hospital setting.
- PHILP2.5 Demonstrate the integration of scientific evidence and other relevant factors when problem solving in the hospital setting.
- PHILP2.6 Demonstrate how to deal with unselected and undifferentiated presentations in the hospital situation.
- PHILP2.7 Demonstrate the management of patients with chronic health problems in the hospital setting.
- PHILP2.8 Demonstrate the use of an integrative holistic perspective in the hospital setting.
- PHILP2.9 Demonstrate the ability to diagnose and manage a broad range of health conditions across multiple systems in the hospital system.

### 3. Population health and the context of general practice

- PHILP3.1 Demonstrate diagnostic processes that relate to community context in the hospital setting (eg. disease prevalence).
- PHILP3.2 Demonstrate the use of a holistic perspective that takes into account social, psychological, cultural and existential dimensions in the hospital setting.
- PHILP3.3 Demonstrate the appropriate treatment of a range of patients not limited by age, gender, ethnicity or health problem in the hospital setting.
- PHILP3.4 Demonstrate the diagnosis and management of diseases at any chronological stage in the process, including health promotion, prevention, case finding, acute presentations, chronic illness and palliative care in the hospital setting.

### 4. Professional and ethical role

- PHILP4.1 Demonstrate diagnostic processes that relate to community context in the hospital setting (eg. disease prevalence).
- PHILP4.2 Demonstrate tolerance of uncertainty when problem solving in the hospital setting.
- PHILP4.3 Demonstrate self awareness and recognition of boundaries in the patient-doctor relationship.
- PHILP4.4 Outline processes for reflective practice when problem solving in the hospital setting.

### 5. Organisational and legal dimensions

- PHILP5.1 Demonstrate appropriate triage processes when working in teams or integrating the expertise of other healthcare providers in the hospital setting.
- PHILP5.2 Demonstrate adherence to the structural elements of the health system that impact on hospital clinical practice (eg. regulations for prescribing and other relevant medical legislation).

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- PHILV1.1 Demonstrate respect for patient autonomy in patient-doctor communications with patients in the primary care setting.
- PHILV1.2 Demonstrate the ability to work in partnership with patients, including negotiating patient centred management plans as determined by patient need, preferences and priorities in the primary care setting.
- PHILV1.3 Demonstrate communication skills required to underpin effective diagnosis and management of the patient (listening, reassuring, explaining, interpreting) and fostering whole patient care in the primary care setting.
- PHILV1.4 Demonstrate the ability to adapt counselling skills to different situations.
- PHILV1.5 Demonstrate continuity of patient care based on patient-determined needs in the primary care setting.
- PHILV1.6 Demonstrate the ability to move between various roles of the clinician according to patient needs (eg. diagnostician, counsellor) in the primary care setting.

### 2. Applied professional knowledge and skills

- PHILV2.1 Demonstrate the ability to recognise serious and urgent problems in the primary care setting.
- PHILV2.2 Demonstrate how to use problem solving skills to collaborate with patients on acceptable management plans in the primary care setting.
- PHILV2.3 Demonstrate the integration of comorbidities when problem solving in the primary care setting.
- PHILV2.4 Demonstrate the appropriate use of investigations and technology in problem solving in the primary care setting.
- PHILV2.5 Demonstrate the integration of scientific evidence and other relevant factors when problem solving in the primary care setting.
- PHILV2.6 Demonstrate how to deal with unselected and undifferentiated presentations in the primary care setting.
- PHILV2.7 Demonstrate the management of patients with chronic health problems in the primary care setting.
- PHILV2.8 Demonstrate the use of an integrative holistic perspective in the primary care setting.
- PHILV2.9 Demonstrate the ability to diagnose and manage a broad range of health conditions across multiple systems in the primary care setting.

### 3. Population health and the context of general practice

- PHILV3.1 Demonstrate diagnostic processes that relate to community context in the primary care setting (eg. disease prevalence).
- PHILV3.2 Demonstrate use of a holistic perspective that takes into account social, psychological, cultural and existential dimensions in the primary care setting.
- PHILV3.3 Demonstrate appropriate treatment of a range of patients not limited by age, gender, ethnicity or health problem in the primary care setting.
- PHILV3.4 Demonstrate diagnosis and management of diseases at any chronological stage in the process including health promotion, prevention, case finding, acute presentations, chronic illness and palliative care in the primary care setting.
- PHILV3.5 Demonstrate responsiveness to the local community health needs.

### 4. Professional and ethical role

- PHILV4.1 Demonstrate tolerance of uncertainty when problem solving in the primary care setting.
- PHILV4.2 Outline processes for reflective practice when problem solving in the primary care setting.

### 5. Organisational and legal dimensions

- PHILV5.1 Demonstrate appropriate triage processes when working in teams or integrating the expertise of other healthcare providers in the primary care setting.
- PHILV5.2 Demonstrate adherence to the structural elements of the health system that impact on primary care clinical practice (eg. regulations for prescribing and other relevant medical legislation).

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

PHILC1.1 Demonstrate regular reflection and skill review of understanding the foundation basis of patient communication skills.

### 2. Applied professional knowledge and skills

PHILC2.1 Demonstrate regular reflection and skill review of understanding the foundation basis of professional knowledge and skills.

### 3. Population health and the context of general practice

PHILC3.1 Demonstrate regular reflection and skill review with respect to changing population health and local community needs.

### 4. Professional and ethical role

PHILC4.1 Demonstrate regular reflection and skill review with respect to professional and ethical roles.

PHILC4.2 Consider ongoing education in conceptual basis of general practice, including more formal academic qualifications.

### 5. Organisational and legal dimensions

PHILC5.1 Demonstrate review of patient continuity issues according to patient-determined needs.

PHILC5.2 Demonstrate adherence to the structural elements of the health system that impact on hospital clinical practice (eg. regulations for prescribing and other relevant medical legislation).

PHILC5.3 Demonstrate knowledge of changes to structural elements of the health system that impact on hospital clinical practice (eg. regulations for prescribing and other relevant medical legislation).

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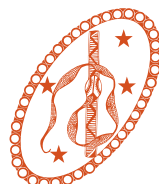


# RACGP Aboriginal and Torres Strait Islander health curriculum statement

7 February 2011



The Royal Australian  
College of General  
Practitioners



The RACGP  
National Faculty of Aboriginal  
and Torres Strait Islander Health  
*Working Together*

## Definitions

In the Aboriginal and Torres Strait Islander health setting there are a number of key terms used. These terms are contested and need to be considered in local contexts. The following definitions are offered as a way to understand these concepts in the context of this Aboriginal and Torres Strait Islander Health Curriculum Statement.

### Aboriginal and Torres Strait Islander health setting

This phrase is used throughout this document to refer to any professional interactions with Aboriginal and/or Torres Strait Islander people, or to discussion about Aboriginal and Torres Strait Islander health issues in any professional setting.

### Aboriginal community controlled health service

Today there are community controlled health services for Aboriginal and Torres Strait Islander people. The National Aboriginal Community Controlled Health Organisation (NACCHO) describes an aboriginal community controlled health service (ACCHS) as: ‘a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).’<sup>1</sup>

### Aboriginal and Torres Strait Islander health

The National Aboriginal Health Strategy Working Party defined health as: ‘Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.’<sup>2</sup> This is the definition used in this curriculum statement.

Consistent with the holistic approach to Aboriginal and Torres Strait Islander health, as well as with the World Health Organization (WHO) model of primary healthcare,<sup>3</sup> delivery of healthcare to Aboriginal and/or Torres Strait Islander patients is more than just a clinical service. The learning objectives in this curriculum statement reflect this approach of broader healthcare delivery by being closely linked across the domains of general practice, and by referencing the individual patient.

### Community control

The 1989 National Aboriginal Health Strategy describes community control as: ‘the community having control of issues that directly affect their community... Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional, state and national levels.’<sup>2</sup>

### Cultural advisor

This term is used in this document to refer to those who provide advice to assist healthcare professionals working in the Aboriginal and Torres Strait Islander health setting. Most commonly and appropriately these people will be Aboriginal and/or Torres Strait Islander.

### Culture

This term has a wide range of meanings but for the purposes of this document the following is used: ‘Culture, for us, then, is more than “a people’s way of life”. Culture tells us what is pretty and what is ugly, what is right and what is wrong. Culture influences our preferred way of thinking, behaving and making decisions. Most importantly, culture is living, breathing, changing – it is never static.’<sup>4</sup>

### Cultural safety

This term describes: ‘an outcome of health practice and education that enables safe service to be defined by those who receive the service.’<sup>4</sup>

## Empowerment

This term describes the state of being empowered.<sup>5</sup> Empowerment cannot be ‘given’. Individuals and groups can only empower themselves when they make informed choices, determine their own fates and acquire resources to support their decisions. Empowerment, then, is part and parcel of self determination.<sup>4</sup>

## Partnership

A term used in this document that refers to a mutually respectful relationship with equity that seeks to achieve agreed outcomes having regard to legal, ethical, cultural and policy considerations.

## Self determination

This term is used to refer to: ‘a process where Indigenous communities take control of their future and decide how they will address the issues facing them.’<sup>6</sup>

## Social determinants of health

These are defined by the WHO as:

‘The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon... Together, the structural determinants and conditions of daily life constitute the social determinants of health.’<sup>7</sup>

In the Aboriginal and Torres Strait Islander health setting this includes the processes of colonisation, dispossession, racism, marginalisation, oppression, stigmatisation, paternalism and prejudice.<sup>8</sup>

## World view

This term is used in this document to describe the perception and experience of existence as shaped by the culture, history, spirituality, belief systems, and political and social interactions of the individual.

# Rationale

The health of Australia’s first peoples is this country’s most pressing and important health priority. Aboriginal and/or Torres Strait Islander people are among the most disadvantaged indigenous peoples in the developed world.<sup>7,9,10</sup>

The available evidence suggests that Aboriginal and Torres Strait Islander people continue to suffer a greater burden of ill health than the rest of the population. Overall, Aboriginal and Torres Strait Islander people experience lower levels of access to health services than the general population, are more likely than non-Indigenous Australian people to be hospitalised for most diseases and conditions, and are more likely to experience disability and reduced quality of life due to ill health, and to die at younger ages than other Australians. Aboriginal and Torres Strait Islander people also suffer a higher burden of emotional distress and possible mental illness than is experienced by the wider community.<sup>11</sup>

Aboriginal and Torres Strait Islander health inequity occurs across all health indicators and many areas of health continue to worsen. Whilst there have been recent gains, the gap is widening as the health of other Australians improves faster.<sup>12</sup>

General practitioners have a key service delivery role in addressing this inequity in partnership with Aboriginal and Torres Strait Islander communities, either within an ACCHS or other GP settings.

General practitioners are also important advocates in improving the health of Aboriginal and Torres Strait Islander people. Australian governments have not only failed to deal with the ongoing consequences of colonisation but in some cases, they have actively promoted racism for political ends. Key health policies such as the National Aboriginal Health Strategy<sup>2</sup> remain largely unimplemented.<sup>8</sup>

It is time that Australia dealt with its history of suppression and oppression of Aboriginal and Torres Strait Islander people in accordance with international best practice in the field of human rights.<sup>8,13</sup> It is time that the rights of Aboriginal and Torres Strait Islander people, including their inalienable rights to self determination and community control are not only recognised but given full expression. Empowerment is central to this critical process in the maturation of modern Australia. To overcome Aboriginal and Torres Strait Islander disadvantage requires political will and leadership. It requires the recognition of the profound, diverse and dynamic cultures of Aboriginal and Torres Strait Islander peoples. It requires the generous provision of appropriate and sustainable resources and the commitment of those in leadership roles in our community.

To most effectively assume these roles of health service provision and advocacy, GPs require relevant knowledge, skills and attitudes. The National Aboriginal Health Strategy (1989)<sup>2</sup> recommends that: 'Tertiary institutions for undergraduate and postgraduate medical, nursing, and paramedical courses be approached to include the compulsory study of Aboriginal culture and history and health issues as part of formal course work,' also recommending that: 'Aboriginal people should be involved in the development and teaching of these units.'

This is the guiding principle by which this document was developed. This curriculum statement sets out a framework of essential attitudes, skills and knowledge required by GPs in order for them to work respectfully and appropriately in Aboriginal and Torres Strait Islander health settings and to advocate for equity in health and related outcomes with Aboriginal and Torres Strait Islander people.

## The five domains of general practice – Aboriginal and Torres Strait Islander health

### Communication skills and the patient-doctor relationship

Culturally safe communication skills are fundamental to the GP's effective engagement in the Aboriginal and Torres Strait Islander health setting.

There is a diversity of cultural beliefs and practices, world views and behaviours among Aboriginal and Torres Strait Islander peoples. General practitioners should respect and be sensitive to this. Aboriginal and Torres Strait Islander peoples' views of health and wellbeing differ to, and are more holistic than, those encapsulated by the biomedical model. They include diverse aspects such as social and emotional wellbeing, community relationships and connection to land. General practitioners who incorporate this into their practice will be better able to understand their Aboriginal and/or Torres Strait Islander patients' needs and motivations. Trust plays a very important role in the development of a therapeutic relationship in the Aboriginal and Torres Strait Islander health setting. A GP may find that they are unable to achieve their desired outcomes until a certain level of trust has been established. General practitioners working in the Aboriginal and Torres Strait Islander health setting must ensure at all times that they avoid a paternalistic approach when delivering healthcare.

A partnership approach is more empowering and is more likely to lead to successful outcomes.

### Applied professional knowledge and skills

'Applied professional knowledge and skills', contains further learning objectives relevant to 'Communication skills and the doctor-patient relationship'. Aboriginal and/or Torres Strait Islander people are more likely to

have a complex interaction of significant health issues including risk factors and medical conditions as well as underlying social and emotional issues. General practitioners require comprehensive and up-to-date knowledge and skills across the spectrum of these health issues.

Management strategies should incorporate an understanding of the views of health and wellbeing, and the social determinants of health and their influence on health behaviours of Aboriginal and/or Torres Strait Islander people and communities. They should be consistent with the comprehensive patient centred approach outlined in the RACGP *Common learning objectives*<sup>14</sup> curriculum document.

A key component of assessment and management in the Aboriginal and Torres Strait Islander health setting is recognising and incorporating the knowledge and skills of Aboriginal and/or Torres Strait Islander health workers, liaison officers and cultural advisers. The capacity to work in a multidisciplinary team partnership approach is a GP key skill for better health outcomes. There are related learning objectives in domains 4 and 5.

## Population health and the context of general practice

Colonisation and government policy decisions have had and continue to have a profound effect on the wellbeing of past, current and future generations of Aboriginal and Torres Strait Islander people. General practitioners need to understand that the healthcare they deliver is affected by these policies and the social determinants they have influenced.

General practitioners working in an Aboriginal and Torres Strait Islander health setting require a sound knowledge of the epidemiology of Aboriginal and Torres Strait Islander health and relevant preventive and other population health strategies.

Family and community can have a powerful influence on the health of Aboriginal and Torres Strait Islander people and the healthcare of Aboriginal and Torres Strait Islander people needs to be understood in the context of family and social relationships.

Effective primary healthcare in an Aboriginal and Torres Strait Islander health setting requires the provision of equitable access to holistic healthcare that addresses the social determinants of health and the right to self determination.

## Professional and ethical role

Cultural advice is a key component of working in an Aboriginal and Torres Strait Islander health setting.

Each GP needs to be conscious of their worldview and its influence on their work within the Aboriginal and Torres Strait Islander health setting. This is an ongoing process across the learning life of the GP and includes openness to feedback from cultural advisors.

Self care strategies are important in order for GPs to overcome the personal impact of the level of disadvantage and inequity in the Aboriginal and Torres Strait Islander health setting.

General practitioners have a role to play in advocating for their patient group and for Aboriginal and Torres Strait Islander health equity.

In the Aboriginal and Torres Strait Islander health setting, academic roles including those of teacher and researcher have the potential to contribute to reducing health inequalities. These roles require an awareness of ethical considerations specific to this setting.

## Organisational and legal dimensions

There are many models of health service delivery to Aboriginal and Torres Strait Islander people. The ACCHS model has a pivotal role in the delivery of primary healthcare to Aboriginal and Torres Strait Islander Australians and is an expression of self determination.

## Learning objectives across the GP professional life

### Medical student

#### Communication skills and the patient-doctor relationship

- Compare Aboriginal and Torres Strait Islander views of health and wellbeing with the prevailing models of healthcare
- Define culturally safe communication with Aboriginal and Torres Strait Islander people
- Demonstrate an understanding of the diversity of Aboriginal and Torres Strait Islander cultures and their relationship to identity in contemporary Australian society
- Explain the importance of establishing trust when communicating with Aboriginal and/or Torres Strait Islander people
- Discuss the differences between a paternalistic approach to health service delivery and an empowering approach and demonstrate how they might influence outcomes in the provision of healthcare to Aboriginal and/or Torres Strait Islander patients.

#### Applied professional knowledge and skills

- Describe conditions and diseases that have specific implications for Aboriginal and/or Torres Strait Islander people
- Discuss the interaction between Aboriginal and/or Torres Strait Islander views of health and wellbeing, social determinants of health, health behaviour and health outcomes
- describe the roles of the Aboriginal and/or Torres Strait Islander health worker, liaison officer and other cultural advisors within the multidisciplinary team in the Aboriginal and Torres Strait Islander health setting.

#### Population health and the context of general practice

- Examine the significance of cultural contact between Aboriginal and/or Torres Strait Islander people and non-Indigenous Australians and its impact on the social determinants of health
- Present an overview of Aboriginal and Torres Strait Islander health epidemiology
- Discuss how family structure, kinship and social relationships of Aboriginal and/or Torres Strait Islander people and communities impact on health decisions and behaviours
- Discuss the concept of primary healthcare in relation to the Aboriginal and Torres Strait Islander health setting.

#### Professional and ethical role

- Discuss how to access cultural advice and why this is important
- Reflect on the GP's own background, worldview and views on health and how this impacts on interactions with Aboriginal and/or Torres Strait Islander people and patients
- Discuss the importance of continual self appraisal of intercultural skills
- Describe the roles of the teacher and the researcher in reducing health inequality in the Aboriginal and Torres Strait Islander health setting
- Explore the issues related to self care when working cross culturally in an Aboriginal and Torres Strait Islander health setting
- Discuss the professional role of a doctor in promoting equity in healthcare outcomes and working against racism among peers, health colleagues, and others in the Australian community.

#### Organisational and legal dimensions

- Compare the range of models of healthcare delivery within the Aboriginal and Torres Strait Islander health

setting.

## **Prevocational doctor (assumed level of knowledge – medical student)**

### **Communication skills and the patient-doctor relationship**

- Demonstrate knowledge of how an Aboriginal and/or Torres Strait Islander person's views on health and wellbeing may impact on their experience of the health system
- Identify strategies for culturally safe communication with Aboriginal and/or Torres Strait Islander people
- Describe the ways in which Aboriginal and/or Torres Strait Islander patients' worldviews may impact on health behaviours including presentations to and interactions with doctors and health services
- Describe skills to establish trust with Aboriginal and/or Torres Strait Islander patients
- Describe the skills required to work in partnership with Aboriginal and/or Torres Strait Islander patients.

### **Applied professional knowledge and skills**

- Demonstrate skills in diagnosis and management of acute and chronic conditions that have specific implications for Aboriginal and/or Torres Strait Islander people
- Demonstrate patient management strategies that incorporate an understanding of health behaviours and their influences of Aboriginal and/or Torres Strait Islander people
- Discuss ways of working as part of a multidisciplinary team that include primary healthcare providers in the Aboriginal and Torres Strait Islander health setting.

### **Population health and the context of general practice**

- Discuss the history of government policies in the area of 'Indigenous affairs' and the outcomes of these policies
- Describe population health approaches relevant to the epidemiology of Aboriginal and Torres Strait Islander health
- Demonstrate how use of knowledge of the influences of family and social structures enhances the care provided to Aboriginal and/or Torres Strait Islander patients
- Examine workplace aspects that could facilitate or obstruct health equity and self determination in relation to Aboriginal and Torres Strait Islander people.

### **Professional and ethical role**

- Demonstrate ability to work in partnership with Aboriginal and/or Torres Strait islander cultural advisors
- Describe how the interaction of worldviews could influence the care provided by a GP in an Aboriginal and Torres Strait Islander health setting
- Describe methods of continual self appraisal of intercultural skills
- Discuss self care strategies to protect against and minimise the potential personal impacts associated with the level of disadvantage when working in an Aboriginal and Torres Strait Islander setting
- Discuss strategies at the systemic, organisational, professional and individual levels to promote health equity and eliminate racism
- Use appropriate guidelines to describe the key features of an ethical approach to research in the Aboriginal and Torres Strait Islander health setting.

### **Organisational and legal dimensions**

- Analyse the history and pivotal role of community controlled health services in the delivery of primary healthcare.

## Vocational registrar (assumed level of knowledge – prevocational doctor)

### Communication skills and the patient-doctor relationship

- Integrate views of health and wellbeing of Aboriginal and Torres Strait Islander people and communities into a holistic approach to clinical practice
- Demonstrate culturally safe communication with Aboriginal and Torres Strait Islander people
- Demonstrate skills used to establish trust with patients
- Demonstrate skills used to develop a partnership approach with patients.

### Applied professional knowledge and skills

- Demonstrate the skills required when working with complex health presentations
- Demonstrate use of holistic management strategies and working in partnership with health workers, liaison officers and cultural advisors.

### Population health and the context of general practice

- Describe ways to deliver healthcare that can help overcome Aboriginal and/or Torres Strait Islander people's health inequities (including the inequities that are a result of government policies)
- Describe preventive and population health approaches in the local Aboriginal and/or Torres Strait Islander communities
- Identify situations in which family and social relationships influence healthcare for Aboriginal and/or Torres Strait Islander patients and demonstrate strategies to optimise health outcomes in such situations
- Describe principles and processes in the development of an Aboriginal and Torres Strait Islander primary healthcare program.

### Professional and ethical role

- Analyse the role of cultural advisors in the delivery of healthcare to Aboriginal and/or Torres Strait Islander patients
- Describe strategies to ensure positive outcomes from the interaction of world views in an Aboriginal and Torres Strait Islander health setting
- Demonstrate self appraisal methods to improve skills in interacting with people in an Aboriginal and Torres Strait Islander health setting
- Demonstrate self care strategies to protect against and minimise the potential personal impacts associated with the level of disadvantage when working in an Aboriginal and Torres Strait Islander setting
- Describe strategies you have used in promoting equity of health outcomes and working against racism
- Discuss the roles of the GP as teacher, learner and researcher in the Aboriginal and Torres Strait Islander health setting.

### Organisational and legal dimensions

- Discuss the organisational, legal and ethical issues that are relevant to delivering primary healthcare in the Aboriginal and Torres Strait Islander health setting both within the Aboriginal community controlled health sector and more broadly.

## Continuing professional development (assumed level of knowledge – vocational registrar)

### Communication skills and the patient-doctor relationship

- Demonstrate openness to learning about the diverse range of Aboriginal and/or Torres Strait Islander worldviews
- Identify resources for review and improvement of consultation skills with Aboriginal and/or Torres Strait Islander patients.

### Applied professional knowledge and skills

- Identify current evidence based, best practice guidelines for prevention, diagnosis and management of conditions with specific implications for Aboriginal and/or Torres Strait Islander people
- Describe strategies for review and improvement of management strategies that reflect Aboriginal and/or Torres Strait Islander views on health and social determinants of health
- Describe the systems within your work place for involvement of Aboriginal and/or Torres Strait Islander health workers, liaison officers and other cultural advisors in patient care. Population health and the context of general practice
- List local resources and services addressing the needs of Aboriginal and/or Torres Strait Islander people
- Describe the GP's responsibility in providing preventive and population health services to Aboriginal and/or Torres Strait Islander people
- Demonstrate awareness of the main health policies that have been designed to address the 'social determinants of health'
- Demonstrate an awareness of changes that could be made in the GP's local area to improve health equity and self determination in relation to Aboriginal and/or Torres Strait Islander people and communities.

### Professional and ethical role

- Describe pathways to access cultural advice appropriate to the GP's current work environment
- Describe methods to regularly review personal values and priorities when working in Aboriginal and Torres Strait Islander health
- List professional supports available to GPs working in an Aboriginal and Torres Strait Islander health settings
- Indicate how a clinician's professional and personal practice promotes health equity, and work against racism
- Identify opportunities for teaching, learning and research related to Aboriginal and Torres Strait Islander health in the practice setting and outline appropriate processes for engaging in these areas.

### Organisational and legal dimensions

- Describe how regular review of systems within the workplace by the GP promotes comprehensive primary healthcare in the Aboriginal and Torres Strait Islander health setting.

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## *Aged care*

### **Contents**

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Definition	63
Curriculum in practice	63
Rationale and general practice context	64
Training outcomes of the five domains of general practice	67
Learning objectives across the GP professional life	70
<i>Medical student</i>	70
<i>Prevocational doctor</i>	71
<i>Vocational registrar</i>	72
<i>Continuing professional development</i>	74
<i>Assumed level of knowledge – vocational registrar</i>	74
References	75

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## Definition

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Aged care in general practice is the management and care of the health of the elderly.

Although aging is associated with increasing levels of disability, most older people have a positive view of their own health with the majority of Australians aged 65 years or older (66%) rating their health as either good, very good or excellent, while 34% report their health as being fair or poor.<sup>1</sup>

The term 'frail aged' is used to describe aged people in need of substantial level of care and support.

The definition of older varies between individuals, communities and cultures. For example, Aboriginal and Torres Strait Islander people have a lower life expectancy than the non-indigenous population and are therefore likely to need aged care services earlier.

The gap in life expectancy between Indigenous and non-Indigenous Australians is smaller at older ages. For example, life expectancy at age 65 years is estimated to be 10.7 years for indigenous males and 12.0 years for indigenous females, around 6 years less for men and 8 years less for women than for non-Indigenous Australian males and females.<sup>1</sup>

Because of this life expectancy difference between Indigenous and non-Indigenous Australians, and the low proportion of Aboriginal and Torres Strait Islander people aged 65 years and over, the terms 'older indigenous person' or 'older Aboriginal/Torres Strait Islander person' is generally considered to include all those who are aged 50 years and over. In 2006, 11% of Indigenous Australians were aged 50 years and over. Women made up 53% of Indigenous Australians aged 50 years and over, and 55% of those aged 65 years and over.<sup>1</sup>

## Curriculum in practice

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A typical presentation that illustrates how the aged care curriculum applies to general practice is:

- Walter, 92 years of age, is a veteran who moved to your area when his wife died 3 years ago. He lives in a converted garage behind his son's house and rarely socialises as he is reliant on others for transport. He has a history of degenerative joint disease, particularly affecting the lower back and right knee, for which he takes regular paracetamol, and hypertension for which he is taking a diuretic. He drinks a stubby of beer each evening, but has never been a heavy drinker. He used to smoke during the war, but hasn't for many years now. He wakes several times each night to use the toilet, which wakes the entire family when he enters the house. Despite this, his bed is often wet in the morning due to nocturnal enuresis. His daughter-in-law is at her wits-end and requests sleeping tablets for Walter. Walter is usually a well dressed man, but on this occasion you notice he is not cleanly shaven and his cardigan has food stains over it. He is vague and forgets your questions. He also appears under-nourished.

## Rationale and general practice context

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Australia has an aging population. In 2010, 13.5% of the Australian population was aged 65 years and over compared to 12.4% in 2000.<sup>2</sup>

Around 34% of general practice patient encounters are with adults aged 65 years and over, and general practitioners are seeing an increasing proportion of older patients, particularly those aged 75 years or over.<sup>3</sup> This presents significant challenges for clinical care, population health and economics of healthcare.

The underlying pathologies among the elderly are the same as among the whole population, but at higher rates. However, there are specific features in the diagnosis and management and the functional and social ability of elderly patients, for example:

- symptoms with no clearly identifiable aetiology
- altered patient presentations
- impact of aging on people with pre-existing conditions, particularly intellectual impairment, mental illness or physical disabilities
- difficulties in cognition and communication
- multiple pathologies
- multisystem disease that often involves chronic disease management
- problems of polypharmacy
- decreased reserves in elderly people (physiological, psychological, financial)
- the importance of functional assessment and support
- sensory deficits such as impaired vision, hearing and balance
- nutrition, physical activity, continence and pain
- the need to relate to carers, relatives and other health professionals
- the need to be aware of community resources
- the importance of continuity of care.

A knowledge of the physiology and epidemiology of aging helps manage conditions that have special significance in the elderly, such as dementia and atherosclerosis.

Quality aged care in general practice requires:

- positive attitudes toward empowering elderly patients to take an active part in maintaining their health
- the ability to deal with and prioritise the numerous problems that the aged may present with, including associated diagnostic and management dilemmas
- feeling comfortable when working with the aged, their families, carers and friends
- working within multidisciplinary healthcare teams
- recognising the special issues (including discrimination) facing older people from diverse backgrounds, including issues of gender differences, ethnicity, poverty and issues of sexuality including sexual preference
- assessment of carer stress to allow early intervention including the possible need for respite care.

## Factors affecting general practice aged care management

Familiarity with government policies and programs that have an impact on the aged<sup>4</sup> and knowledge of the increased burden of disease in the elderly helps plan general practice aged care. These policies aim to promote health and to prevent and reduce the loss of function from illness, injury and disability. Examples of such policies and programs include rational prescribing practices, such as the *Quality use of medicines guidelines*,<sup>5</sup> which consider the cost and benefits of prescribing medications to individual patients, helps incorporate public health initiatives into daily clinical practice, and health promotion and preventive care in the elderly.

Costs of different care options, such as home support versus institutional care, may influence general practice management options. Patients may need to be treated outside of the general practice setting, eg. at home, at hospital or in an aged care facility.

Cultural and linguistic diversity, socioeconomic status, gender, family and community supports, and geographical location may affect the needs, acceptance and availability of services and activities for the aged.

Cultural differences, perceptions and expectations of aging may affect levels of carer responsibility and involvement.

General practitioners need to be aware of the special services available to help meet the needs of Aboriginal and Torres Strait Islander people.

General practitioners need to be aware of how age related discrimination can affect the management of older patients.

Informed consent may be impaired in the elderly and the care of aged patients may involve carers, issues of power of attorney and regulatory administrative bodies such as guardianship boards. This includes discussing, formulating and documenting advanced care plans and decisions concerning the end-of-life.

Older patients may require assessment for fitness to drive and laws may affect their licence eligibility. Other legal requirements which may require general practice involvement, include pension eligibility, taxi concessions, and death and cremation certificates including coronial obligations. Clinicians need a knowledge of legislative reporting obligations to state public health units that may involve older patients.

Older patients are especially at risk of adverse patient safety outcomes, especially in relation to the inappropriate use of physical or medication induced restraint, missed diagnoses due to failure to evaluate vague or unclear expressed symptoms, and failure to understand management instructions.

General practitioners identifying elder abuse have legal reporting responsibilities.

## Multidisciplinary aged care and general practice

The rise of multidisciplinary teams in primary care (eg. aged care assessment teams) is changing the face of the care of older people. General practitioners need to ensure that the appropriate continuity of care and coordination of management are provided to maintain older people in an optimal state of health in the best possible setting.

General practitioners working as part of a multidisciplinary team need to understand the roles, knowledge and skills of each member of the aged care team including allied health professionals, support agencies and specialist aged care teams.

General practitioners need to be aware that comprehensive care plans can result in complex referrals, service overlaps and gaps requiring accurate written health summaries for patients and carers to avoid confusion during continuity of care.

## Related curriculum areas

Most other curriculum areas have implications for aged care, including:

- *Acute serious illness and trauma* for managing emergencies
- *Chronic conditions*
- *Disability*
- *Mental health*
- *Multidisciplinary healthcare*
- *Multicultural health* for successful cross-cultural communication including the correct use of translators
- *Oncology*
- *Pain management*
- *Palliative care*
- *Population and public health* regarding disease prevention.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- AGET1.1 Promote comfortable discussion with aged people and accommodate patients with failing sight, hearing, mental capacities and physical limitations.
- AGET1.2 Incorporate cultural and linguistic issues into patient-doctor communication, including aged patients who do not speak English as their first language.
- AGET1.3 Use sensitivity when communicating with next-of-kin or carers, particularly in circumstances where the patient lacks the capacity to make an informed decision, or where there is a question of consent for treatment.
- AGET1.4 Provide clear direction and patient care instructions to family, caregivers and residential aged care facility staff.

## 2. Applied professional knowledge and skills

- AGET2.1 Adapt knowledge of all areas of medicine to the care of the aged, while recognising where this may differ in the aged and that the context and goals of diagnosis, management and prognosis may differ.
- AGET2.2 Know how diagnosis, management and prognosis in older people may be affected by the presence of altered presentations, comorbidities (and their treatments), and socioeconomic and cultural factors.
- AGET2.3 Understand the biological and psychosocial processes of aging, and how this affects the interpretation of investigations and the metabolism of drugs.
- AGET2.4 Consider and evaluate the role of screening, prevention and health promotion in aged patients.
- AGET2.5 Diagnose and treat classic geriatric presentations such as confusion, falls, leg ulcers and incontinence.
- AGET2.6 Know the general practice implications of multiple pathological processes occurring simultaneously.
- AGET2.7 Manage distressing symptoms, even in the absence of demonstrable pathology (eg. dizziness, isolation, constipation and dry skin).
- AGET2.8 Be aware of the concepts of care versus cure and the impact on quality of life.
- AGET2.9 Consider the goal of maintaining functional status.
- AGET2.10 Manage the wide range of conditions seen mainly in the aged (eg. dementia, congestive heart failure, Parkinson disease).
- AGET2.11 Manage the problems of polypharmacy and the systematic recording and review of medications.
- AGET2.12 Discuss sensitively and assist formulating and documenting advanced care plans and decisions concerning the end-of-life.
- AGET2.13 Making appropriate arrangements for care of the dying and for the bereaved is an important skill in the care of the aged.
- AGET2.14 Perform or refer patients for appropriate practical procedures, which are often used in the management of conditions common in the elderly.

### 3. Population health and the context of general practice

- AGET3.1 Understand how to use government policies that impact on aged care, such as specific Medicare aged care payments.
- AGET3.2 Use comprehensive care plans funded under government chronic disease plans and other aged care initiatives.
- AGET3.3 Understand how knowledge of the increased burden of disease in the elderly helps plan general practice aged care.
- AGET3.4 Understand how aged care policies and programs that aim to promote health, prevent and reduce the loss of function from illness, injury and disability work and how these policy changes may have implications for general practice aged care.
- AGET3.5 Use rational prescribing practices that consider the cost and benefits of prescribing medications to individual patients.
- AGET3.6 Incorporate health promotion and prevention into aged care.
- AGET3.7 Understand how the issues involved in the cost of different care options, such as home support versus institutional care, may influence general practice management options.
- AGET3.8 Understand how cultural and linguistic diversity, socioeconomic status, gender, family and community supports, and geographical location may affect the needs, acceptance and availability of services and activities for the aged.
- AGET3.9 Understand how cultural differences, perceptions and expectations of aging may affect levels of carer responsibility and involvement.
- AGET3.10 Be aware of the special services available to help meet the needs of Aboriginal and Torres Strait Islander people.
- AGET3.11 Assessment of carer stress allows early intervention including the possible need for respite care.

### 4. Professional and ethical role

- AGET4.1 Adopt appropriate professional attitudes including awareness of how age discrimination can affect the management of older patients.
- AGET4.2 Do not deny useful treatment purely on the basis of age when evaluating the benefits and risks of proposed treatments.
- AGET4.3 Work effectively as part of a multidisciplinary team and understand the role, knowledge and skills of each member of the aged care team.
- AGET4.4 Understand the ethics of how informed consent may be impaired in the elderly and the care of aged patients may involve carers, issues of power of attorney and regulatory administrative bodies such as guardianship boards.
- AGET4.5 Practise ethical principles regarding informed consent in the discussion, formulation and documentation of advanced care plans and decisions concerning the end-of-life.
- AGET4.6 Identify elder abuse (including physical, psychological, social, financial, sexual abuse and neglect) and understand professional legal reporting responsibilities.
- AGET4.7 Pay close attention to patient safety risks in the aged, especially in relation to inappropriate use of physical restraint, missed diagnoses due to failure to evaluate vague or unclear expressed symptoms and ensuring that patient information is as clear as possible.

## 5. Organisational and legal dimensions

- AGET5.1 When providing aged care services work in conjunction with government and nongovernment agencies and specialist aged care assessment teams. This includes working with the Aged Care GP Panels Initiative, aged care assessment teams and many other community services.
- AGET5.2 Identify and work with complex referrals, service overlaps and gaps, as well as differing criteria for service eligibility.
- AGET5.3 Where appropriate, treat patients outside of the general practice setting, eg. at home, hospital or in an aged care facility.
- AGET5.4 Accurately document appropriate health summaries for patients and carers to assist continuity of care, including care plans that include the systematic recording of medications to help manage polypharmacy.
- AGET5.5 Assess, as appropriate, older patients for fitness to drive and understand the laws affecting licence eligibility in the aged.
- AGET5.6 Assist with legal requirements where appropriate, including pension eligibility, taxi concessions, death and cremation certificates.
- AGET5.7 Know legislative reporting obligations to state public health units that may involve older patients.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- AGELM1.1 Describe the impact of sensory impairment on effective patient-doctor communication and measures to address these barriers.
- AGELM1.2 Describe the cultural and social barriers to patient-doctor communication with older people.

### 2. Applied professional knowledge and skills

- AGELM2.1 Discuss theories of the physiology of aging.
- AGELM2.2 Summarise the health promotion in the elderly including nutrition and exercise.
- AGELM2.3 Describe how physical and psychosocial changes of aging affect lifestyle, including how people cope and situations in which they can no longer cope.
- AGELM2.4 Describe common psychological and mental health issues in the elderly.
- AGELM2.5 Describe methods of assessing patient mental health status and cognitive function.
- AGELM2.6 Describe the impact of multiple health conditions on patient management.
- AGELM2.7 Discuss pharmacology in older people, including altered drug metabolism.

### 3. Population health and the context of general practice

- AGELM3.1 Describe the epidemiological patterns of common medical and psychological conditions that affect older people.
- AGELM3.2 Discuss the social and behavioural impact of aging.
- AGELM3.3 Discuss how ethnicity, socioeconomic status, gender, family and community supports and geographical location may affect aged care service needs, including acceptance and availability of services and activities.

### 4. Professional and ethical role

- AGELM4.1 Describe how age discrimination has an impact on patient care and access to services.
- AGELM4.2 Discuss issues of patient autonomy in older people.
- AGELM4.3 Describe the principles behind power of attorney and advanced medical care plans and identify the legislative processes that implement them.
- AGELM4.4 Outline the requirements for high quality multidisciplinary care in older people.

### 5. Organisational and legal dimensions

- AGELM5.1 Summarise the social structure of aged care health services including structures in community, hospital and residential aged care settings.
- AGELM5.2 Discuss the role of family and carers in providing aged care, including carer stress.
- AGELM5.3 Describe how age discrimination laws may have an impact on elderly patients.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- AGELP1.1 Describe how consultation environmental factors such as privacy, background noise and location can affect communication with the elderly.
- AGELP1.2 Describe how families and carers may affect patient communication.
- AGELP1.3 Explain and discuss investigations and therapies of common diseases of the elderly to the patient and his/her carers and family.

### 2. Applied professional knowledge and skills

- AGELP2.1 Demonstrate how to take a history and examination in order to elicit common diseases that affect the aged, involving carers when appropriate.
- AGELP2.2 Investigate and refer appropriately for diseases affecting the aged.
- AGELP2.3 Describe how the biological process of aging affects the interpretation of investigations and the metabolism of drugs.
- AGELP2.4 Discuss the special issues of drug therapy in the aged, including changes in pharmacokinetics and the special risks of drug therapy including polypharmacy.

### 3. Population health and the context of general practice

- AGELP3.1 Identify common medical and psychological conditions that affect older people.
- AGELP3.2 Outline the care issues resulting from age discrimination.
- AGELP3.3 Describe the stresses encountered by those who care for the aged.

### 4. Professional and ethical role

- AGELP4.1 Identify how age discrimination has an impact on patient care and access to services.
- AGELP4.2 Discuss the sensitive treatment of older patients, including issues relating to patient autonomy.
- AGELP4.3 Describe legislation relating to power of attorney and advanced medical plans.

### 5. Organisational and legal dimensions

- AGELP5.1 Describe effective discharge planning for the elderly including planning for continuity of care, assessment for safety and support services at home and future respite.
- AGELP5.2 Describe the indications for and regulatory requirements of various levels of residential care.
- AGELP5.3 Describe the effect systems of care may have on the health of the elderly.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- AGELV1.1 Use strategies that promote comfortable discussion with the aged including patients with failing sight, hearing and mental capacities.

### 2. Applied professional knowledge and skills

- AGELV2.1 Demonstrate the comprehensive assessment and management of patients who present with aged care problems including biological, psychological and social aspects.
- AGELV2.2 Identify how diseases may present differently in the aged compared to younger people (eg. dementia, congestive cardiac failure, Parkinson disease).
- AGELV2.3 Describe the problems of polypharmacy and the importance of systematic recording and review of medication.
- AGELV2.4 Describe the changes in normal ranges of laboratory values in older people.
- AGELV2.5 Manage distressing symptoms whether or not there is demonstrable pathology (eg. confusion, falls, dizziness, isolation, constipation, decreased morbidity, leg ulcers and disease masquerades).

### 3. Population health and the context of general practice

- AGELV3.1 Outline the relevance of aged care to general practice.
- AGELV3.2 Summarise the complexities of providing services and healthcare funding to the aged.
- AGELV3.3 Identify the stresses encountered by those who care for the aged.
- AGELV3.4 Describe strategies for addressing age discrimination in aged healthcare.
- AGELV3.5 Describe the appropriate use of community services and resources for the aged and their carers (eg. nursing homes, hostels, community resources, respite care).

### 4. Professional and ethical role

- AGELV4.1 Evaluate specialist treatment recommended for aged patients by discussing the benefits and risks of suggested treatment, and ensure that patients are not denied useful treatment purely on the basis of age.
- AGELV4.2 Describe how to advocate for the elderly in accessing aged care and other resources.
- AGELV4.3 Discuss ethical issues related to the aged regarding autonomy, power of attorney, legal and medical plans, including guardianship board, principles of informed consent, and euthanasia.
- AGELV4.4 Discuss the physical, psychological and financial forms of elder abuse.
- AGELV4.5 Demonstrate the ability to provide multidisciplinary aged care.

## 5. Organisational and legal dimensions

- AGELV5.1 Describe the importance of respite care for the wellbeing of patients and their carers.
- AGELV5.2 Describe the role of each member of the aged care multidisciplinary team.
- AGELV5.3 Access resources and aids, which assist the elderly (eg. visual and hearing aids, dosette boxes, mobility aids, home care services).
- AGELV5.4 Demonstrate how to use medical records systems and care plans to document the care of older people.
- AGELV5.5 Outline methods for providing adequate services to meet the needs of patients who are unable to attend the doctor's surgery.
- AGELV5.6 Describe practice processes to facilitate communication with hospitals and other facilities in relation to discharge planning.
- AGELV5.7 Arrange and provide appropriate care for the dying and the bereaved.
- AGELV5.8 Comply with the legal requirements for certificates of sickness, eligibility for pension, taxi concessions, certification of death and cremation.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

AGELC1.1 Demonstrate maintenance of skill level in communicating with the elderly.

### 2. Applied professional knowledge and skills

AGELC2.1 Demonstrate up-to-date management of conditions in the elderly.

AGELC2.2 Demonstrate up-to-date knowledge of prescribing issues in the elderly.

AGELC2.3 Incorporate evidence based advances into the care of the elderly.

AGELC2.4 Consider the need for more specialised training in aged care by those practitioners with a high caseload or interest in aged care.

### 3. Population health and the context of general practice

AGELC3.1 Identify the impact of local demography of older patients on the general practice.

AGELC3.2 Keep up-to-date with changes in aged care policies.

AGELC3.3 Identify the impact of changes and initiatives in government aged care policy on general practice.

AGELC3.4 Identify the expectations and the diversity of views presented by culturally and linguistically different patient populations and the impact of these on general practice aged care.

### 4. Professional and ethical role

AGELC4.1 Identify own gaps in knowledge and skills in relation to aged care.

AGELC4.2 Consider involvement in residential care facility or nursing home care.

AGELC4.3 Incorporate professional development needs for the general practice care of older people into ongoing quality assurance activities.

### 5. Organisational and legal dimensions

AGELC5.1 Seek information and training in the use of government funded programs such as the Aged Care GP Panels Initiative, other aged care initiatives and community services to assist in improving the quality of aged care.

AGELC5.2 Consider the use of up-to-date specific assessment tools in managing the elderly.

AGELC5.3 Consider the use of computerised medical records when managing elderly patients, especially those with multiple comorbidities.

AGELC5.4 Review practice processes to facilitate communication with hospitals and other facilities in relation to discharge planning.

AGELC5.5 Identify local aged care facilities and resources.

AGELC5.6 Maintain a list of locally available aged care resources including community care services (eg. meals on wheels).

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# *Children and young people's health*

## Contents

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Definition	79
Curriculum in practice	79
Rationale and general practice context	80
Training outcomes of the five domains of general practice	82
Learning objectives across the GP professional life	84
<i>Medical student</i>	84
<i>Prevocational doctor</i>	86
<i>Vocational registrar</i>	88
<i>Continuing professional development</i>	90
References	92

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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## Definition

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Children and young people's health in general practice covers physical, psychological and social primary healthcare from birth to adulthood.

The age ranges of childhood and adolescence overlap, reflecting that the developmental transitions through childhood, adolescence and adult life are not determined only by reference to chronological age. Physiological, psychological and social developmental milestones are also markers of maturation, and these vary considerably between individuals.

The end of adolescence is usually marked by the acquisition of skills and responsibilities such as financial independence, entering the workforce and undertaking lifelong partnerships. More recently these skills and responsibilities have not been attained until a later stage in life.<sup>1</sup> For international epidemiological comparisons, most authorities define adolescence as the period between ages 10–18 years.<sup>2–5</sup>

This statement uses the term 'young person' rather than adolescent. This reflects the current preference of professionals working in the field.

## Curriculum in practice

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Typical presentations that illustrate how the children and young people's health curriculum applies to general practice include:

- Annisa, 8 years of age, is brought in by her mother because the school is concerned she may have attention deficit hyperactivity disorder. A bright child, she is not performing well academically and is frequently getting into trouble for disruptive behavior. The family has recently moved in with relatives due to financial difficulty. As her mother is explaining the situation, she is constantly reprimanding Annisa, who is prowling your room picking up and putting down multiple objects. Annisa appears to pay no attention and her mother rapidly escalates to raising her voice and grabbing her by the shoulder. At this point Annisa sweeps her arm sideways, knocking a tray of instruments onto the floor. She then sits in the corner scowling.
- Emily, 17 years of age, has been sent home from school, having fainted in the classroom. Her mother is at work but rang to say she is worried that Emily is over-stressed about her exams and has been uncharacteristically emotionally volatile at home. She is also concerned that Emily has not been eating well for a while and tends to have hot chips and soft drink for dinner, as both parents do not usually arrive home until late. Despite this, Emily looks healthy, with a slim build, but with an uncommunicative attitude.

## Rationale and general practice context

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The prenatal, childhood and adolescent phases of development strongly influence an individual's subsequent health, wellbeing and opportunities in life.<sup>6</sup> Therefore the general practice care of children and young people takes on a special role in creating future opportunities, especially for Aboriginal and Torres Strait Islander people and other disadvantaged communities.<sup>7–10</sup>

Families consult general practitioners and community nurses for problems arising in infancy more commonly than any other health professional.<sup>11,12</sup> Many presentations that appear medical at first may be related to parenting issues such as parental exhaustion, lack of confidence or even guilt. For example, the single most common problem for families nurturing infants is poor sleep, which affects up to 45% of families. Sleep deprivation has a high impact on the family in a number of measurable ways. Inappropriate medicalisation of this and similar presenting problems may result in these families missing out on effective evidence based help.<sup>13–15</sup>

When the patient is a newborn, an infant or a child, the rewards of the work are enhanced when the doctor is able to establish a social relationship with the patient and their family. This includes insight into the child's view of their situation and managing parental concerns in a way that enhances the parents' understanding, self confidence and capacity to manage. Parents report that they value doctors who understand the complexities of family life.<sup>16</sup>

Recent evidence has indicated a rising prevalence of childhood neuropsychiatric disorders, which has resulted in an emphasis on the importance of healthcare providers supporting families in the early years of child-parent interaction for the long term promotion of mental health in children and young people.<sup>17,18</sup>

General practitioners often see the same young children as community nurses and other healthcare workers, and need to communicate appropriately for optimal patient care.<sup>19</sup>

Ten percent of consultations in general practice are with patients aged 15–24 years,<sup>20</sup> but many young people do not feel comfortable raising certain important health issues with the doctor,<sup>21</sup> while others experience barriers to accessing general practice care. General practitioners often find it challenging to provide optimal care for young people for a number of reasons.<sup>22–25</sup>

The Australian Institute of Health and Welfare reports that among young people:<sup>26</sup>

- there has been a large decline in death rates (mostly due to fewer injury deaths)
- asthma hospitalisations and notifications for hepatitis (A, B and C) have decreased and there is improved survival for cancer: survival for melanoma is now very high
- favourable trends are occurring in some risk and protective factors, such as smoking and illicit substance use
- most sexually active Year 10 and Year 12 students are using contraception
- the majority of young people rate their health as 'good', 'very good' or 'excellent'
- most young people are achieving national minimum standards for reading, writing and numeracy, are fully engaged in study or work, and have strong support networks
- most young people are able to get support from outside the household in times of crisis.

These gains in the health of young people need to be contrasted against rising rates of diabetes and sexually transmissible infections, high rates of mental disorders and, for males, road transport accident deaths. Many young people are overweight or obese, not physically active or eating enough fruit and vegetables, and drinking at risky or high-risk levels. Many young people are also victims of alcohol or drug related violence, or are homeless.<sup>26</sup>

General practitioners need to implement evidence based guidelines for developmental surveillance and early intervention strategies for children and young people, including immunisation, as documented in the *RACGP Guidelines for preventive activities in general practice*.<sup>27</sup>

Psychosocial factors affect the wellbeing of young people regardless of whether there is co-existing organic disease or disability. These factors include multiple and often conflicting cultural influences and pressures. Threats to adolescent health and wellbeing largely arise from psychosocial factors,<sup>16</sup> yet healthy adolescent development often involves behaviours that constitute health risks. General practitioners need to be able to assess risk and protective factors in the context of the developmental tasks of adolescence.<sup>28,29</sup>

Communication difficulties between doctors and young people, either real or perceived, are barriers to young people accessing medical care in any setting.<sup>21–25</sup> These arise in part because of the unique developmental processes that occur during adolescence which may make the young person self-conscious, mistrusting or cautious about authority figures such as doctors. Young people often have critical concerns about privacy and confidentiality and may be anxious about dealing independently with systems of healthcare that are not familiar to them. Doctors' confidence in dealing with young people is improved by training in communication skills.<sup>30</sup>

Systemic counselling approaches are often used when managing children and young people's health, for example strengths based counselling, which seeks to recognise strengths of families, and/or other systems to support the child/young person.<sup>31</sup>

General practitioners in Australia are becoming increasingly involved with the adult care of young people with chronic disease or disability, who face particular challenges when they become adults and need to move from tertiary paediatric care to adult models of care.<sup>32,33</sup>

Adolescent friendly practices can make a practice attractive to young people. Practices need to be child, family and young people friendly with a friendly atmosphere and ease of access. External practice systems need to enable communication and collaboration with the community, colleagues in general practice, and other health professionals. High quality information management enhances clinical practice, especially by supporting audits of clinical work involving children and young people.

Capacity at the 'system level' refers to opportunities for working with others that can only be put in place as a result of negotiation by general practice organisations and government in collaboration with other stakeholder organisations in the community. Practices need to ensure that the multidisciplinary care of young people negotiates successful and high quality management plans.

## Health inequality in children and young people

Inequalities in health status have been identified in Australian children when measured at school entry, which then continues to increase throughout primary and secondary education,<sup>34,35</sup> which can then threaten long term health. This widening health inequality can result in cumulative health vulnerabilities in children of poorer socioeconomic status, challenging the effectiveness of one-to-one general practice consultations in improving health outcomes.

General practitioners increasingly need to be able to work in teams within the practice and to collaborate efficiently with primary healthcare professionals in the community and other community resources in order to be able to support families most at risk.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- CYPT1.1 Establish an effective social relationship with the newborn, infant or child and their family, including insight into the child's view of their situation and manage parental concerns in a way that enhances the parents' understanding, self confidence and capacity to manage.
- CYPT1.2 Recognise that effective communication between doctors and young people, either real or perceived, are barriers to young people accessing medical care in any setting.
- CYPT1.3 Understand the developmental processes that occur during adolescence which may make the young person self conscious, mistrusting or cautious about authority figures such as doctors.
- CYPT1.4 Recognise how young people often have critical concerns about privacy and confidentiality and may be anxious about dealing independently with systems of healthcare that are not familiar to them.

## 2. Applied professional knowledge and skills

- CYPT2.1 Know the social and cultural factors that influence the wellbeing of patients and their families, especially the importance of the early years of child-parent interaction in promoting physical and mental health in children and young people.
- CYPT2.2 Manage urgent, life threatening problems (eg. impending upper airway obstruction, significant dehydration or a child or young person at risk).
- CYPT2.3 Manage situations where serious disease (eg. meningococcal bacteraemia) may be indistinguishable from a common self limiting condition at the initial presentation, formulate a differential diagnosis to exclude a serious illness, and use a sufficient safety net to cover any dangerous possibilities within the differential diagnosis.
- CYPT2.4 Identify children at risk of abuse, neglect, homelessness or nonaccidental injury, and negotiate 'safety net' arrangements with the parents.
- CYPT2.5 Understand how families under stress may find that minor childhood illness or difficult behaviour threaten their ability to cope and may then seek inappropriate investigations, treatments and management.
- CYPT2.6 Explore any sources of family distress in a way that promotes family functioning.
- CYPT2.7 Effectively manage common causes of preventable childhood morbidity such as asthma or anxiety.
- CYPT2.8 Help, where appropriate, young patients with a disability to find strategies that build on their strengths and work around their weaknesses and recognise the need to either supply support or mobilise other providers.
- CYPT2.9 Understand how psychosocial factors affect the wellbeing of young people, regardless of whether there is co-existing organic disease or disability, including how healthy adolescent development often involves behaviours that constitute health risks.
- CYPT2.10 Assess risk and protective factors in the context of the developmental tasks of adolescence.

### 3. Population health and the context of general practice

- CYPT3.1 Implement evidence based guidelines for developmental surveillance and early intervention strategies for children and young people.
- CYPT3.2 Understand the community where the GP works in order to target identified problems in local health areas and priorities.
- CYPT3.3 Manage the special health requirements of particular subpopulations of young people, such as young people with high risk sexual and drug use behaviours, those subject to violence and the homeless.
- CYPT3.4 Understand the particular health requirements of Aboriginal and Torres Strait Islander young people.
- CYPT3.5 Understand the impact of socioeconomic gradients on the health of children and young people.

### 4. Professional and ethical role

- CYPT4.1 Recognise professional and ethical issues specific to childhood and adolescence.
- CYPT4.2 Understand that the best interests of the child or young person may not coincide with the perceived best interests of parents, carers or other significant adults.
- CYPT4.3 Advocate for the child or young person, while respecting their views, when negotiating treatment or other interventions.
- CYPT4.4 Encourage patient and parent independence and confidence in managing problems or illnesses where appropriate.
- CYPT4.5 Understand the negative consequences of guilt as a tool of patient management (eg. when dealing with the choices parents make about infant feeding or lifestyle choices of young people).
- CYPT4.6 Utilise systemic counselling approaches, when appropriate, in the management of children and young people's health.

### 5. Organisational and legal dimensions

- CYP5.1 Support and develop effective systems inside and outside the practice for children and young people's health.
- CYP5.2 Promote a child, family and young people friendly practice, including easy access.
- CYP5.3 Minimise the barriers often experienced by young people when seeking access to care in general practice.
- CYP5.4 Ensure that practice systems enable communication and collaboration with the community, colleagues in general practice and other health professionals.
- CYP5.5 Understand how high quality information management enhances clinical practice, especially by supporting audits of clinical work involving children and young people.
- CYP5.6 Ensure confidentiality measures are in place that respect the needs of young people, especially in relation to consent.
- CYP5.7 Recognise and implement reporting requirements mandated by law.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- CYPLM1.1 For children:
- CYPLM1.1.1 outline major communication skills and give examples of each
  - CYPLM1.1.2 describe how to establish rapport with babies and young children
  - CYPLM1.1.3 describe the similarities and differences between the processes of admitting a child to hospital and consulting with children in the community.
- CYPLM1.2 For young people:
- CYPLM1.2.1 generate useful questions under each subheading of the HEADSS (Home environment, Education and employment, Eating, peer related Activities, Drugs, Sexuality, Suicidality/depression, and Safety from injury and violence) schema
  - CYPLM1.2.2 explain confidentiality and its limits to young people.

### 2. Applied professional knowledge and skills

- CYPLM2.1 For children:
- CYPLM2.1.1 describe the clinical characteristics of life-threatening illnesses in childhood
  - CYPLM2.1.2 describe the clinical characteristics of common illnesses in childhood
  - CYPLM2.1.3 discuss evidence based interventions for common problems in the first year of life
  - CYPLM2.1.4 outline developmental milestones
  - CYPLM2.1.5 discuss resilience and the relation to protective and risk factors in a child's family and social environment
  - CYPLM2.1.6 demonstrate health checks in children, including the ability to examine vision in children aged 3–5 years.
- CYPLM2.2 For young people:
- CYPLM2.2.1 describe the developmental tasks of adolescence
  - CYPLM2.2.2 discuss cultural factors that might influence a young person's experience of adolescence
  - CYPLM2.2.3 describe the physiology of puberty
  - CYPLM2.2.4 describe the clinical characteristics of common adolescent specific health conditions
  - CYPLM2.2.5 discuss the importance of the substages of adolescent development for understanding risk taking behaviours
  - CYPLM2.2.6 discuss resilience and its relation to protective and risk factors in a young person's family and social environment.

### 3. Population health and the context of general practice

- CYPLM3.1 Describe strategies for health surveillance, prevention and promotion for children and young people as recommended in the RACGP 'red book'.
- CYPLM3.2 Describe a systematic approach for understanding factors affecting breastfeeding, and their management.
- CYPLM3.3 Describe the health status of Aboriginal and Torres Strait Islander children and young people.

### 4. Professional and ethical role

- CYPLM4.1 Discuss potential conflicts between the best interests of children and young people and the perceived best interests of their parents or carers.
- CYPLM4.2 Discuss the evidence that young people value confidentiality.

### 5. Organisational and legal dimensions

- CYPLM5.1 Outline the legal requirements for notifying children and young people at risk.
- CYPLM5.2 Outline the steps involved in notifying children and young people at risk.
- CYPLM5.3 Discuss the barriers young people face in accessing healthcare.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

CYPLP1.1 For children:

- CYPLP1.1.1 demonstrate the ability to reflect on the use of communication skills in each consultation with children and their families
- CYPLP1.1.2 demonstrate the ability to reflect on the structure of each consultation with children and their families
- CYPLP1.1.3 demonstrate how to negotiate time alone with parents when the child is better protected from hearing their parents' explicit concerns.

CYPLP1.2 For young people:

- CYPLP1.2.1 demonstrate the ability to reflect on the strengths and weaknesses of each consultation with a young person
- CYPLP1.2.2 demonstrate the ability to negotiate time alone with a young person when appropriate.

### 2. Applied professional knowledge and skills

CYPLP2.1 For children:

- CYPLP2.1.1 demonstrate how to institute the immediate management of life-threatening illness
- CYPLP2.1.2 discuss the elements of management plans to protect children who may not be seriously ill at the time of presentation, but could become seriously unwell in the near future
- CYPLP2.1.3 describe and implement evidence based strategies in the management of sleep deprivation and feeding difficulties in the first 12 months of life
- CYPLP2.1.4 demonstrate how to perform a supra pubic bladder tap or catheter urine, where appropriate
- CYPLP2.1.5 show how to monitor growth and development.

CYPLP2.2 For young people:

- CYPLP2.2.1 demonstrate the management of common adolescent specific health conditions
- CYPLP2.2.2 demonstrate how to assess risk and protective factors, where appropriate, using schema such as HEADSS
- CYPLP2.2.3 discuss the management of dangerous conditions (often called 'red flag' conditions), such as anxiety, depression, substance use disorder, eating disorder and suicidality.

### 3. Population health and the context of general practice

- CYPLP3.1 Demonstrate the skills required for health surveillance, prevention and promotion as recommended in Chapter 3, preventive activities in children and young people, of the RACGP 'red book'.

### 4. Professional and ethical role

- CYPLP4.1 Discuss the implications of conflict between the management needs of patients, parents or doctors.
- CYPLP4.2 Demonstrate a nonjudgmental approach to managing parents of young people.
- CYPLP4.3 Demonstrate the ability to seek assistance/supervision when appropriate.
- CYPLP4.4 Demonstrate management of the professional boundaries between doctors and young people.

### 5. Organisational and legal dimensions

- CYPLP5.1 Demonstrate competence in the process of notifying children and young people at risk, where legally or ethically appropriate.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

CYPLV1.1 For children:

- CYPLV1.1.1 demonstrate how to conclude consultations so that parents and children leave feeling that they have been understood and that common ground was negotiated in developing the management plan
- CYPLV1.1.2 demonstrate maintenance of parent trust without inappropriate prescribing or investigating
- CYPLV1.1.3 demonstrate how to empower parents to have the knowledge and confidence needed to monitor the safety of unwell children.

CYPLV1.2 For young people:

- CYPLV1.2.1 demonstrate the ability to develop young people's trust
- CYPLV1.2.2 demonstrate the ability to accurately assess young people, where appropriate, using the HEADSS schema effectively to build trust and understanding
- CYPLV1.2.3 demonstrate the ability to discuss confidentiality and its limits
- CYPLV1.2.4 demonstrate the ability to communicate appropriately with parents or carers without breaching confidentiality.

### 2. Applied professional knowledge and skills

CYPLV2.1 For children:

- CYPLV2.1.1 demonstrate recognition and institution of management of life-threatening illness
- CYPLV2.1.2 show how to assist families to manage common concerns, illnesses and disabilities
- CYPLV2.1.3 demonstrate the diagnosis and management of common breastfeeding problems
- CYPLV2.1.4 demonstrate the management of children at risk of abuse, neglect, homelessness or nonaccidental injury
- CYPLV2.1.5 demonstrate the ability to monitor growth and development
- CYPLV2.1.6 detect elements in a child's environment that favour wellbeing, and elements that diminish or risk wellbeing
- CYPLV2.1.7 outline how to assist in developing parenting skills.

CYPLV2.2 For young people:

- CYPLV2.2.1 demonstrate minimisation of preventable morbidity by appropriate management of medical conditions common in young people
- CYPLV2.2.2 describe how to assist young people in managing their sexual health
- CYPLV2.2.3 demonstrate the ability to recognise young people at risk of suicide and institute immediate management

- CYPLV2.2.4 demonstrate the ability to recognise young people at risk of abuse or neglect and institute immediate management
- CYPLV2.2.5 demonstrate how to recognise young people whose behaviour is a risk to their health and respond constructively
- CYPLV2.2.6 describe how to recognise common psychological and psychiatric problems in adolescent patients
- CYPLV2.2.7 outline evidence based management of psychological and psychiatric problems that are common in young people
- CYPLV2.2.8 describe how to assist parents of young people to develop their parenting skills.

### 3. Population health and the context of general practice

- CYPLV3.1 Discuss health inequality in relation to Australian children and young people, including in Aboriginal and Torres Strait Islander people.
- CYPLV3.2 Demonstrate the implementation of health surveillance, prevention and promotion as recommended in the RACGP 'red book'.
- CYPLV3.3 Discuss barriers to implementing these strategies in current general practice, including health inequalities.
- CYPLV3.4 Discuss solutions for problems faced by young people with a chronic disease who need to move from paediatric to adult care.
- CYPLV3.5 Describe common and serious patterns of childhood accidental and traumatic injuries and related prevention measures, such as parent education, that can be used to reduce the risk of these injuries.

### 4. Professional and ethical role

- CYPLV4.1 Demonstrate the ability to discuss the special health issues relating to children and young people's health with illustrations from cases or other examples arising from experience in practice.
- CYPLV4.2 Discuss professional strategies used to address key child health issues, including the role of multidisciplinary team work.

### 5. Organisational and legal dimensions

- CYPLV5.1 Demonstrate the ability to maintain confidentiality in practice.
- CYPLV5.2 Demonstrate features that make the practice child and young people friendly.
- CYPLV5.3 Describe the GP's role in multidisciplinary teams in addressing children and young people's health.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- CYPLC1.1 For children:
- CYPLC1.1.1 demonstrate ongoing review of the communication skills required to understand the real concerns of children and their families
  - CYPLC1.1.2 demonstrate an understanding of the complexities of family life and how to utilise the consultation in a way that increases parental confidence and competence.
- CYPLC1.2 For young people:
- CYPLC1.2.1 demonstrate the ability to maintain trusting relationships with young people
  - CYPLC1.2.2 demonstrate the ongoing ability to assess the health of young people, where appropriate, using schema such as HEADSS
  - CYPLC1.2.3 demonstrate the ability to integrate ongoing confidential healthcare with young people, their parents, carers and other professionals.

### 2. Applied professional knowledge and skills

- CYPLC2.1 For children:
- CYPLC2.1.1 review knowledge and skills required for effective and efficient healthcare of children and their families, as outlined in the introduction to this domain
  - CYPLC2.1.2 maintain the skills necessary to diagnose and manage common breastfeeding problems
  - CYPLC2.1.3 describe the role of positive parenting programs in assisting parents with raising children and promoting good parent-child communication.
- CYPLC2.2 For young people:
- CYPLC2.2.1 demonstrate the monitoring of competence in assessment and management of medical conditions, sexual health and health risk behaviours of young people, including the recognition of young people at risk of suicide, abuse or neglect and institute immediate management
  - CYPLC2.2.2 demonstrate the ability to monitor competence in working collaboratively with young people, their parents and carers and other professionals as appropriate, in managing complex problems of adolescence
  - CYPLC2.2.3 demonstrate the ability to formulate management plans for common psychological and psychiatric problems in adolescent patients.

### 3. Population health and the context of general practice

- CYPLC3.1 Demonstrate ways of overcoming the barriers to effective implementation of health surveillance, prevention and promotion as recommended in Chapter 3 of the RACGP 'red book'.
- CYPLC3.2 Describe trends in the morbidity, mortality and 'health inequality' of Australian children and young people.
- CYPLC3.3 Review contributions to the activities of general practice organisations in order to progress the goals of this curriculum statement.
- CYPLC3.4 Describe how to contribute to improving the transition from paediatric to adult care for those with chronic disease or disabling conditions.

### 4. Professional and ethical role

- CYPLC4.1 Demonstrate ongoing review of key professional issues in relation to the health issues of children and young people.
- CYPLC4.2 Review opportunities for further professional development in children and young people's health.

### 5. Organisational and legal dimensions

- CYPLC5.1 Demonstrate ongoing review to practice policies and procedures that deal with the high quality healthcare of children and young people.
- CYPLC5.2 Describe and discuss difficulties encountered in implementing these policies.

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## *Disability*

### **Contents**

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Definition	97
Curriculum in practice	97
Rationale and general practice context	98
Training outcomes of the five domains of general practice	99
Learning objectives across the GP professional life	100
<i>Medical student</i>	100
<i>Prevocational doctor</i>	102
<i>Vocational registrar</i>	104
<i>Continuing professional development</i>	106
References	107

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## Definition

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Modern concepts of disability have broadened the traditional focus on individual impairment to one that recognises that the effect of impairment on an individual depends not only on the underlying condition, but also on environmental and social factors. Therefore, a person with an impairment may not necessarily be disabled or handicapped by it. Alternatively, inadequate supports in an environment may lead to an unnecessary handicap as a result of an impairment. This holistic concept of disability, which combines medical and social models, is reflected in the World Health Organization's International Classification of Functioning, Disability and Health (ICF).<sup>1,2</sup> The concept of support needs – which can assist the person to overcome some of these limitations – has recently been added to the classification. There are three main types of disability.

**Physical disability** – disability associated with physical impairment and physical activity limitation such as when performing day-to-day activities.

**Intellectual disability** – the presence of significant limitations in intellectual functioning (usually defined as IQ less than 70), and in adaptive behaviour (conceptual, social and practical skills). This type of disability originates before the age of 18 years.<sup>3</sup>

**Developmental disability** – the presence of physical, intellectual and/or social (autism spectrum disorders) impairment with deficits in adaptive functioning, with an onset in the developmental period. Intellectual disability may be a prominent feature in people with developmental disability.

**Important note: unless otherwise stated, this curriculum uses the term 'disability' to include physical, intellectual and developmental disability.**

Some disabilities are often associated with comorbid conditions, for example, intellectual disability and epilepsy, cerebral palsy and vision impairment or epilepsy.<sup>4</sup> These comorbidities, and their associated cognitive and communication difficulties, can present barriers to accessing healthcare. Clinicians should not let the disability distract from or overshadow these health problems, rather they should approach them as they would with a person without a disability.

Other disabilities may also be acquired in adult life including sensory, psychiatric, musculoskeletal and neurological disabilities. These can have a significant impact on the affected person's life and as such need to be addressed.

## Curriculum in practice

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Typical cases that illustrate how the disability curriculum applies to general practice include:

- Joni, 18 years of age, has Down syndrome. She presents with her family who are concerned she has been spending a lot of time with her new boyfriend, whom she met through her workplace. Her parents say that they think that Joni may be sexually active and that she is not capable of making any decisions for herself.
- Zack, 38 years of age, has an intellectual disability. He has recently moved to new supported accommodation in your area and arrives with a disability support worker for treatment of a laceration, which occurred while preparing dinner. Zack has minimal medical records and you are not sure of when Zack last visited a general practitioner.

## Rationale and general practice context

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In 2003, an estimated 3.9 million Australians had some degree of disability. Of these 1.2 million (6% of the population) had severe or profound core activity limitations. These include increases in intellectually disabling conditions, sensory or speech impairment or psychiatric disability. The reported prevalence rates of disabling conditions associated with childhood, such as attention deficit hyperactivity disorder and autism-related disorders, has substantially increased in the past decade.<sup>5,6</sup>

People with disability make up a significant part of most general practice populations. These people may have multiple comorbidities and GPs have a key role in the management of these disabilities and associated health problems.<sup>7,8</sup> In addition, the disability itself can be a barrier to accessing health services, and the GP will often have a role in facilitating appropriate and timely access to services, as well as providing ongoing management of health issues.

According to the Australian Institute of Health and Welfare, in 2007–2008, 46% of people aged 15–64 years with severe or profound disability reported poor or fair health, compared to 5% for those without a disability.<sup>5</sup>

People aged under 65 years with severe or profound disability had a higher prevalence rate of all types of selected long term health conditions than people without a disability. The prevalence of physical long term health conditions was higher for people with both mental health problems and severe or profound disability than for those with mental health problems but no disability.<sup>7</sup>

Australian GPs and registrars indicate that they receive inadequate training to care for people with intellectual disability and consider they need better training in the assessment of behaviour problems, mental disorders, communication, sexuality, neurological problems and an increased understanding of other common comorbidities – be they related to a syndrome or not.<sup>8–10</sup> The vast majority of GPs are interested in improving their skills, knowledge and management of this patient population.<sup>11</sup>

In addition to disability related conditions, people with disability will have the full range of medical conditions affecting people without disabilities and will require access to appropriate services. This includes the need for access to the full range of preventive health services such as smoking cessation, nutritional and other population based health initiatives.

People with disability come from a wide range of backgrounds. Practitioners need to recognise the special issues (including discrimination) facing people with disabilities from diverse backgrounds including issues of gender difference; ethnicity and poverty; and issues of sexuality, including sexual preference.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- DIST1.1 Use communication to build the foundation of good general practice management of patients with disabilities.
- DIST1.2 Use appropriate additional communication skills and strategies when a patient with disabilities has significant communication difficulties, whether due to cognitive, social or physical impairment.
- DIST1.3 Ensure good communication between doctor and patient and, where appropriate, family and/or support workers.

## 2. Applied professional knowledge and skills

- DIST2.1 Understand that people with disabilities have the same medical issues as the rest of the population, although certain disabilities may be associated with an increased (or decreased) risk of particular medical conditions.
- DIST2.2 Know the cause or underlying pathology of the disability and use this to inform medical management.
- DIST2.3 Employ the same diagnostic and management strategies and standards that apply to patients without a disability when providing medical care to people with a disability, irrespective of the medical condition and underlying disability.

## 3. Population health and the context of general practice

- DIST3.1 Understand how people with disabilities often encounter barriers to participating in and accessing the services they choose and require.
- DIST3.2 Be aware of the social, financial and legal frameworks and services that support people with a disability and their families and carers within the community.
- DIST3.3 Know population based measures for disability prevention (eg. periconception folate supplementation).

## 4. Professional and ethical role

- DIST4.1 Ensure focusing the patient encounter on, and maintaining respect for, the person with the disability.
- DIST4.2 Be aware of the impact of the disability on the person's life and the need to employ the same standards of care that apply to patients without a disability.
- DIST4.3 Understand that patients and families come from diverse social and cultural backgrounds and how this may influence their attitudes and knowledge with respect to disability.

## 5. Organisational and legal dimensions

- DIST5.1 Understand how legislative frameworks empower individuals and protect those who are not able to advocate for themselves.
- DIST5.2 Ensure that good practice procedures, including those for regular review and follow up, underpin proactive medical management of people with a disability.
- DIST5.3 Understand that good practice procedures and systems are particularly important to the care of people including those with a disability, who find it difficult to understand and organise their medical care.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- DISLM1.1 Describe the centrality of effective and efficient communication in people's physical, emotional and social wellbeing across the lifespan in relation to people with a disability.
- DISLM1.2 Identify the roles and responsibilities of each person in a communication exchange when managing a person with a disability.
- DISLM1.3 Explain how different types of disability may have an impact on communication.
- DISLM1.4 Describe the range of communication techniques, including behaviours that are used by people with disabilities.
- DISLM1.5 Demonstrate skills and appropriate strategies to optimise communication with people with communication difficulties due to cognitive and/or physical impairment.

### 2. Applied professional knowledge and skills

- DISLM2.1 Describe the genetic basis, pathophysiology and for major disabilities outline the implications of these conditions for various organ systems including:
  - DISLM2.1.1 Down syndrome
  - DISLM2.1.2 fragile X syndrome
  - DISLM2.1.3 intellectual disability
  - DISLM2.1.4 autism spectrum disorders
  - DISLM2.1.5 cerebral palsy
  - DISLM2.1.6 developmental delay
  - DISLM2.1.7 acquired brain injury
  - DISLM2.1.8 quadriplegia and hemiplegia.
- DISLM2.2 Explain the importance of making a diagnosis of the underlying cause of a person's disability, where possible.
- DISLM2.3 Outline the likelihood of comorbidities that exist with various syndromes/aetiological diagnoses and their interactions.
- DISLM2.4 Explain the features and implications of the aetiological (eg. Down syndrome, fragile X syndrome) and functional (eg. cerebral palsy, intellectual disability, autism) diagnostic labels of developmental disability for medical care.
- DISLM2.5 Describe how medication and medical and psychiatric conditions may affect behaviour.
- DISLM2.6 Recognise common psychiatric disorders in people with intellectual disabilities that present as changed or disturbed behaviour.
- DISLM2.7 Explain the importance of proactive orderly health management and preventive health strategies for people with a disability, particularly people who have a cognitive and/or communication impairment.

### 3. Population health and the context of general practice

- DISLM3.1 Describe the barriers (including physical, communication, attitudinal) to medical care and community participation that may be encountered by people with disabilities.
- DISLM3.2 Describe the effect of sociocultural factors on the behaviour and lifestyle of people with disabilities.

### 4. Professional and ethical role

- DISLM4.1 Outline the importance of shared responsibility, teamwork and a co-ordinated and multidisciplinary approach to ensure that patients receive high quality medical care.
- DISLM4.2 Critically reflect on your own and the community's attitudes toward people with developmental and acquired disability.
- DISLM4.3 Identify the role of the health professional in providing quality healthcare to people with disabilities within a wider service system.
- DISLM4.4 Describe the fundamental ethical and legal principles underlying the provision of healthcare, particularly as they apply to people with cognitive and/or communication impairment in a clinical setting. These should include the concepts of duty of care, informed consent and information sharing issues.
- DISLM4.5 Outline the repercussions of a diagnosis of a disability in a family member on the lives of parents, siblings and the community.
- DISLM4.6 Demonstrate recognition of some of the commonly held attitudes toward sexuality and disability, and understand how they influence the individual's opportunities for full sexual and emotional development.

### 5. Organisational and legal dimensions

- DISLM5.1 Outline the importance of practice procedures that support the proactive provision of healthcare including procedures for annual health reviews, patient follow up and recall, and the provision of screening and preventive healthcare.
- DISLM5.2 Outline the role of guardianship and administrative boards and tribunals.
- DISLM5.3 Describe the role that social and financial services have in supporting the person with a disability to play a valued role in their community, and to have the life patterns and opportunities available to their nondisabled peers.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- DISLP1.1 Demonstrate courteous and respectful treatment of people with disabilities.
- DISLP1.2 Work effectively with carers, support workers and advocates to optimise health outcomes for people with disabilities.
- DISLP1.3 Develop skills in obtaining recent and past medical history from carers and available patient records.

### 2. Applied professional knowledge and skills

- DISLP2.1 Describe the known aetiological factors in each of the major developmental disabilities and know how to approach the task of establishing an aetiological diagnosis, including how to access relevant information and resources.
- DISLP2.2 Appreciate the availability and importance of preconception review, advice and medications (eg. folate replete diet and supplementation in anticonvulsant use).
- DISLP2.3 Demonstrate awareness of the likelihood of comorbidities that exist with various syndromes/aetiological diagnoses and their interactions.
- DISLP2.4 Describe possible underlying factors in changed, or challenging behaviour, as a presentation in people with intellectual disability and acquired brain impairment.
- DISLP2.5 Demonstrate an understanding of the clinical management of the sexual health of people with disabilities and in particular, developmental disabilities.
- DISLP2.6 Outline the possible challenges of performing procedures on people with disabilities and be able to discuss ways in which these may be anticipated and managed.
- DISLP2.7 Demonstrate awareness that the indicators (especially symptoms) of serious illness may be difficult to elicit in people with cognitive impairment, and determine ways to overcome these difficulties.

### 3. Population health and the context of general practice

- DISLP3.1 Outline the advances in international descriptions of disability in terms of organ impairment, activity limitation and participation restriction, and their influence on medicolegal statements.
- DISLP3.2 Be aware of the research evidence related to the health status, need for screening and health needs of people with disabilities.
- DISLP3.3 Describe the range of social, financial and legal services available to support people with a disability and their families and carers, and know where to find further information about these services.

## 4. Professional and ethical role

- DISLP4.1 Demonstrate advocacy for providing quality healthcare to people with disabilities within the working environment.
- DISLP4.2 Comply with ethical and legal principles underlying the provision of healthcare, particularly as they apply to people with a cognitive and/or communication impairment in a clinical setting. These should include the concepts of duty of care, informed consent and information sharing issues.

## 5. Organisational and legal dimensions

- DISLP5.1 Identify practice procedures that support the proactive provision of healthcare including procedures for annual health reviews, patient follow up and recall, and the provision of immunisation, screening and preventive healthcare.
- DISLP5.2 Consider the appropriate clinical environment for the patient with a disability to optimise their access, ease, comfort and participation in the consultation.
- DISLP5.3 Demonstrate how to establish if a patient with a disability has the capacity to give consent and, if not, know from whom consent should be obtained.
- DISLP5.4 Demonstrate an understanding of the role of the Public Guardian and the Guardianship and Administration Act or legislative equivalent that applies to your local jurisdiction.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- DISLV1.1 Demonstrate a range of communication strategies to optimise the participation in the consultation of a patient with communication difficulty resulting from a disability.
- DISLV1.2 Demonstrate an ability to communicate effectively with carers and/or advocates who are providing support to a person with a disability, taking account of both the need to share information with those involved in the patient's care and the patient's right to confidentiality.
- DISLV1.3 Demonstrate how to provide sensitive genetic counselling and advice for patients and their families, and know where to source further genetic information and advice.

### 2. Applied professional knowledge and skills

- DISLV2.1 Demonstrate an understanding of the concept and importance of behavioural and physical phenotypes.
- DISLV2.2 Demonstrate an understanding of the health inequalities experienced by people with intellectual disability, the associated barriers to health equity and the role of the GP in overcoming these barriers.
- DISLV2.3 Describe the role of the main services and systems available within the community that support people with disabilities and their families.

### 3. Population health and the context of general practice

- DISLV3.1 Demonstrate recognition of the need for health surveillance of groups with developmental disability including mortality, morbidity and level of population screening.
- DISLV3.2 Demonstrate encouragement and facilitation of people with disabilities to participate in health promotion programs, especially good nutrition and exercise.
- DISLV3.3 Demonstrate provision of proactive care to families of a person with a developmental disability based on an understanding of family lifecycle and changing individual and family needs. This includes being sensitive to the effect on the carer's physical and mental health and identifying appropriate local supports and resources.
- DISLV3.4 Outline the public health implications of antenatal testing and folate supplementation. Also describe the impact of the underlying intent and basis of these on the individual with a developmental disability, their family and their community.
- DISLV3.5 Demonstrate awareness of the need to initiate and provide an annual health assessment for people with cognitive impairments, including examination.
- DISLV3.6 Act as an advocate for people with disabilities and their families, to enhance their access to health and community services.
- DISLV3.7 Identify the range of social, financial and legal services available to support people with disabilities and their families and carers, and know where to find further information about these services.

## 4. Professional and ethical role

- DISLV4.1 Demonstrate respect for the right of the individual with a disability to make life choices that may involve a risk to their health, and understanding of the need to balance this right to autonomy with duty of care.
- DISLV4.2 Describe the importance of being part of a multidisciplinary team in working with people with disabilities, appreciate the value and role of all members of a multidisciplinary healthcare team, and understand how the medical practitioner can contribute to the healthcare of people with a developmental disability through such a team.
- DISLV4.3 Outline the different cultural understandings of disability and their effect on family reactions and responses to the diagnosis of a developmental disability.

## 5. Organisational and legal dimensions

- DISLV5.1 Demonstrate practice procedures which support the proactive provision of healthcare, including procedures for annual health reviews; patient follow up and recall; and the provision of immunisation, screening and preventive healthcare.
- DISLV5.2 Demonstrate practice process to establish if a patient with a disability has the capacity to give consent and, if not, know from whom consent should be obtained.
- DISLV5.3 Demonstrate practice mechanisms in place to ensure compliance with the role of the Public Guardian and the Guardianship and Administration Act, or legislative equivalent that applies to your local jurisdiction.
- DISLV5.4 Outline the practice procedures, which ensure the appropriate clinical environment is in place, for patients with disabilities to optimise their access, ease, comfort and participation in the consultation.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- DISLC1.1 Demonstrate regular review of communication skills with people with cognitive and physical impairment as part of ongoing professional development activities.

### 2. Applied professional knowledge and skills

- DISLC2.1 Demonstrate regular review of advances in knowledge and practice in the care of people with disabilities.

### 3. Population health and the context of general practice

- DISLC3.1 Maintain up-to-date knowledge of the social, financial and legal services available to support people with a disability, and their families and carers, and where to find further information about such services.
- DISLC3.2 Demonstrate that preventive health measures, including immunisation and population screening, are inclusive of the needs of people with disabilities.
- DISLC3.3 Demonstrate ability to perform a comprehensive screening health assessment on a person with a disability, and understanding the high risk conditions associated with each particular disability.

### 4. Professional and ethical role

- DISLC4.1 Maintain up-to-date knowledge of changes in legislative requirements for people with disabilities.
- DISLC4.2 Consider further courses or specialist training in the area, as appropriate for the skill required.

### 5. Organisational and legal dimensions

- DISLC5.1 Regularly review practice procedures that support the proactive provision of healthcare including procedures for annual health reviews; patient follow up and recall; and the provision of immunisation, screening and preventative healthcare.
- DISLC5.2 Regularly review potential practice procedures to ensure access for people with disabilities.

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## *Doctors' health*

### Contents

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Definition	111
Curriculum in practice	111
Rationale and general practice context	112
Training outcomes of the five domains of general practice	114
Learning objectives across the GP professional life	116
<i>Medical student</i>	116
<i>Prevocational doctor</i>	118
<i>Vocational registrar</i>	119
<i>Continuing professional development</i>	120
References	121

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## Definition

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Doctors' health is the understanding and practise of safe-health behaviours that are necessary to attain 'a state of complete ideal physical, mental, social wellbeing and not merely the absence of disease and infirmity.'<sup>1</sup> These behaviours include:

- self care
- safe, effective and appropriate utilisation of the health system
- involvement in appropriate personal health screening
- practice of appropriate health promoting behaviours.

Doctors' health also includes the provision of appropriate healthcare to other doctors and their family members.

Physician impairment is defined as any physical, mental or behavioural disorder that interferes with the ability to engage safely in professional activities.

## Curriculum in practice

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The following case illustrates how the doctors' health curriculum applies to general practice:

- Your practice partner has retired and so far you have been unable to recruit a replacement. Consequently, your usually busy week has become chaotic as you struggle to manage 12 hour days with hospital ward rounds and nursing home visits. You have started skipping meals and drinking too much coffee, which means that when you do reach home you are edgy and often enter into arguments with your family. You are worried your relationship with your partner is no longer stable. After dinner you have a glass of wine to unwind and fall asleep in the chair. Waking around midnight, you spend 2 hours on the internet answering emails before going to bed. At 6 am the telephone rings with a request for you to do a house call on the way to work. Your head pounds and you wonder what your blood pressure could be.

## Rationale and general practice context

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Doctors, historically, have been reported to have high rates of mental health problems, alcoholism and drug-use disorders.<sup>2</sup> This has often been reported in the context of disciplinary action taken against them.

Doctors should see themselves as people who practise medicine, ie. people first and foremost, with all the human needs and weaknesses that apply to the rest of the population.<sup>3-5</sup>

Doctors and their families are a disadvantaged group within society by virtue of their poorer access to a doctor of choice, including medical families.<sup>6</sup> They may have poorer health outcomes as patients in the health system due to under- and over-treatment and a failure to utilise their own referral networks when in crisis.

However, in addition to maintaining health for personal wellbeing, doctors also have a professional obligation to maintain their own health in order to ensure they perform optimally when treating patients.

The medical profession needs to support doctors in maintaining their own health by recognising the benefits both the doctor and the wider community. Doctors have both a personal and professional responsibility to ensure they are accessing and optimising quality healthcare.

Doctors have difficulty accessing healthcare for many reasons. Education to ensure that doctors can effectively confront the barriers to effective health access is essential; these barriers may be personal or related to the culture of the medical profession. Minimising these barriers requires an understanding of what it is like to be a patient and what it is like to be involved in caring for a medical colleague.<sup>7</sup>

Recent literature has focused on mental health issues affecting doctors including stress, depression and job satisfaction. Doctors' health encompasses more than this, and includes their physical health and the social supports they establish during their lives, both with their peers and outside their medical circle. Doctors' health includes many diverse issues: illness, impairment, the impact of medicolegal issues and the personal safety of the doctor in their work environment.<sup>8</sup>

Special issues may confront some groups of GPs. For example, rural practitioners may be confronted with issues of reduced access to independent care and longer working hours. Similarly, medical students have unique pressures, as do new medical graduates.<sup>9,10</sup>

As a profession, GPs have an obligation to all patients, including doctor-patients, to ensure they have access to appropriate care.

Boundary issues are a significant component of doctors' health, and understanding the boundaries within the doctor-patient relationship is one aspect of this issue. Decisions regarding self treatment and the need for independent healthcare is another. Medical families may also suffer problems with their access to healthcare, and it is important that doctors and their families are educated on how to recognise the boundary issues involved.

Doctors have a professional obligation<sup>11</sup> to ensure the welfare of impaired colleagues by providing appropriate support in their access of care, ensuring the community is protected from potential harm and assisting those returning to the workplace.

### The doctor as a patient

Doctors need to confront issues relating to being a patient at some stage in their life, and to be aware that some doctors find this transition difficult.

Specific issues of confidentiality and participation in the process of shared decision making may need to be considered.

Doctors should be advised of the advantage in having an independent GP to assist with their healthcare and should actively seek to develop rapport with their own GP before they develop any significant health issues.

Doctors need to understand the distinction between being ill and being impaired, and to be prepared to voluntarily withdraw from work in the event of impairment and to notify those who can assist.

Doctors, like all patients, have the right to confidentiality and privacy, and should not have any of their details disclosed unless obliged ethically or legally to do so. Fear of lack of access to a confidential doctor is a fear disclosed by some doctors.<sup>2,8</sup>

Doctors have special issues relating to their own health, and treatment should be sensitive to these needs. For example, some doctors may have difficulty accepting a diagnosis when they have spent a large amount of their professional life treating the same or similar conditions. Denial of illness and vulnerability may be an important issue, and doctors may also self-medicate, including adjusting dosages, without consulting their treating doctor.

Like all patients, doctors should take responsibility for their own health and be proactive about professional and occupational health needs, such as immunisation and complying with legislative health requirements in the case of illness or impairment, which threatens patient safety, as well as being proactive about their own health (eg. exercise and other health promotion activities).

## Treating doctors – the doctor as a doctor's doctor

All GPs are likely to treat a doctor as a patient during their career and will need to recognise there are some specific issues that may arise in such consultations.

Doctors treating medical practitioners need to ensure that the same due care is offered when caring for doctors as for other patients. General practitioners should follow their usual method of history taking, examination and investigation, as they would with any other patient without taking shortcuts or making assumptions.

Treating doctors should recognise that doctor-patients require the same explanations of investigations and management and be prepared to act as an advocate within the medical system as they would for all patients.

Doctor-patients often need to be reassured that they have made the right decision in seeking medical care, even if the problem appears to be a minor one. The barriers that many doctors experience when they access healthcare need to be recognised, and issues of confidentiality are especially important. Doctor-patients need to be encouraged to follow routine preventive health screening and healthy lifestyle practices, just as other patients are encouraged to do. They need to be included in the routine recall system for follow up and screening and encouraged to develop a continuing regular relationship with their practitioner.

Treating doctors should encourage doctor-patients to participate in a shared decision making process with the guidance normally offered to any patient. Doctor-patients should be allowed to be the patient and not be expected to make decisions without support. This therapeutic alliance should take into account the health literacy of the patient without making assumptions, but nevertheless acknowledging the doctor-patient's special knowledge. During this process the treating doctor needs to be aware of the issues of transference within the relationship.<sup>3,7</sup>

There is a need to actively negotiate the potential concerns of self-treatment. If the treating doctor feels that the doctor-patient should take time off for illness, then this will need to be discussed and the appropriate certificates offered.

When caring for an ill and potentially impaired doctor, treating doctors need to accept their professional and ethical responsibility to ensure that the doctor receives care and that the general community is protected.<sup>12</sup>

## Related curriculum areas

Refer also to the curriculum statements:

- *Teaching, mentoring and leadership in general practice*
- *Quality and safety*
- *Practice management.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- DOCT1.1 Take on the role of patient when communicating with your own health provider.
- DOCT1.2 Seek medical assistance when required in appropriate environments.
- DOCT1.3 Have the necessary skills to communicate to the doctor-patient.
- DOCT1.4 Communicate to the doctor-patient that their concerns will be treated confidentially.
- DOCT1.5 Acknowledge the difficulties that doctors have when taking on the patient role.

## 2. Applied professional knowledge and skills

- DOCT2.1 Know the importance of a doctor maintaining their own physical and emotional wellbeing and how a doctor's health affects their provision of healthcare.
- DOCT2.2 Know the factors that influence doctors' health.
- DOCT2.3 Understand a doctor's personal occupational health and safety requirements (eg. vaccination requirements, managing needlestick injuries and complying with requirements if they have an infectious disease, including chronic blood borne viruses).
- DOCT2.4 Have the necessary skills to recognise and manage stress, both at the workplace and outside the workplace.
- DOCT2.5 Be aware of the impact of transference and counter transference within the therapeutic relationship when a doctor treats other doctors.

## 3. Population health and the context of general practice

- DOCT3.1 Understand that as well as doctor-specific conditions, doctors experience the same diseases as the general community and need to be provided the same screening and health promotional activities as the rest of the population.
- DOCT3.2 Be aware of doctor-specific conditions such as a higher risk of specific conditions including anxiety, relationship difficulties, depression, suicide and the use of psychoactive medication.
- DOCT3.3 Understand that an impaired doctor who continues to work presents a potentially serious health risk to the community.

## 4. Professional and ethical role

- DOCT4.1 Maintain health to ensure optimal performance in patient care and seek care and assessment in the event of illness.
- DOCT4.2 Comply with personal occupational health requirements, including vaccinations, as healthcare workers are at increased risk of acquiring specific diseases (eg. blood borne viruses).
- DOCT4.3 Develop and seek to use appropriate personal and professional networks to facilitate communication about stressful situations and ensure appropriate support.
- DOCT4.4 Limit work hours to a safe level.
- DOCT4.5 Develop a relationship with an independent GP that enables the maintenance of healthcare with appropriate confidentiality.
- DOCT4.6 Have a network of personal and professional support to assist resolution of a reaction to difficult personal situations.

- DOCT4.7 Ensure the maintenance of personal relationships outside the medical career.
- DOCT4.8 Practice healthy living, including healthy diet and exercise.
- DOCT4.9 Actively pursue leisure activities beyond medical practice to maintain a balanced life.
- DOCT4.10 Understand the implications of self management of illness, including self prescribing and the risks associated with this behaviour.
- DOCT4.11 Ensure that the doctor's family has access to independent healthcare.
- DOCT4.12 Understand how to deal with a colleague who is exhibiting inappropriate physical, psychological or emotional behaviour, including knowledge of the relevant medical board requirements in this situation.
- DOCT4.13 Demonstrate compassion toward doctor-colleagues and provide support through life crises.
- DOCT4.14 Be aware that the professional isolation and stigma that colleagues experience often contributes to health problems.
- DOCT4.15 Understand the need to have well defined personal and professional boundaries when dealing with a distressed colleague.
- DOCT4.16 Be aware that treating a sick doctor can be professionally challenging, which may affect the ability to care effectively for sick doctors.
- DOCT4.17 Ensure that the treating doctor maintains appropriate confidentiality.

## 5. Organisational and legal dimensions

- DOCT5.1 Understand the safe personal use of the medical/health system, including the safe use of medicines.
- DOCT5.2 Actively negotiate to work safe hours in a safe working environment.
- DOCT5.3 Know the relevant medical registration and medical indemnity requirements for your own medical care.
- DOCT5.4 Provide a safe environment for the doctor-patient to raise all relevant health concerns.
- DOCT5.5 Understand requirements for reporting to the relevant registration board and medical indemnity requirements regarding impaired colleagues.
- DOCT5.6 Be aware of backup resources for support of both the treating doctor and the doctor-patient.
- DOCT5.7 Approach the care of such doctors with the same high standards of care that is delivered to all patients.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- DOCLM1.1 Describe the differences between communicating with doctor-patients and the communication skills required to treat patients.

### 2. Applied professional knowledge and skills

- DOCLM2.1 Describe the risks of access to drugs in the workplace, self medication and the unique occupational health and safety issues faced by doctors with diagnostic knowledge and prescribing ability.
- DOCLM2.2 Describe the aspects of the professional medical culture that may result in adverse health outcomes for doctors including invulnerability, adjusting to diagnosis of illness and seeking treatment and support from colleagues.

### 3. Population health and the context of general practice

- DOCLM3.1 Describe contemporary patterns of illness in the medical profession, balancing an understanding of mental health problems and substance use disorders with an understanding of physical health and other health issues.

### 4. Professional and ethical role

- DOCLM4.1 Describe the potential tension in the role of being a patient as well as a doctor.
- DOCLM4.2 Describe the potential demands on medical students from their own families and social networks to offer assistance, including advocating for others, due to their medical knowledge.
- DOCLM4.3 Describe the relationship between ill health and physician impairment in the areas of mental and physical health.
- DOCLM4.4 Describe the hazards related to the knowledge of, and access to, drugs in the workplace.
- DOCLM4.5 Reflect on own current level of health system usage and potential personal barriers to accessing healthcare.
- DOCLM4.6 Describe the potential stigma experienced by doctors and students when attempting to access help, especially for addiction including fear of punitive measures.
- DOCLM4.7 Describe the reasons why a doctor should have their own skilled, confidential GP.
- DOCLM4.8 Describe when a doctor should seek healthcare.
- DOCLM4.9 Demonstrate compliance with occupational vaccination requirements (eg. hepatitis B immunisation).
- DOCLM4.10 Demonstrate that you have your own GP.
- DOCLM4.11 Demonstrate personal health promotion, self care, life balance and spirituality issues.
- DOCLM4.12 Describe the advantages of confidential personal supportive networks throughout the medical course and during a doctor's medical career.
- DOCLM4.13 Describe the professional obligations in assisting colleagues to access support.
- DOCLM4.14 Discuss the impact of early identification of self care problems (eg. as students); which may affect future career opportunities.

## 5. Organisational and legal dimensions

- DOCLM5.1 Describe the importance of disability insurance and medical defence insurance.
- DOCLM5.2 Describe the role of medical boards in doctors' health.
- DOCLM5.3 Discuss the ethical and legal importance of confidentiality when treating doctors.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- DOCLP1.1 Describe how the culture of medicine affects a doctor's ability to communicate their own health needs to other doctors.

### 2. Applied professional knowledge and skills

- DOCLP2.1 Describe how to recognise the signs of a colleague in difficulty.
- DOCLP2.2 Demonstrate the ability to treat other doctors equitably and appropriately.
- DOCLP2.3 Describe the potential pitfalls of self treatment.
- DOCLP2.4 Discuss how to increase personal resilience by developing strategies for dealing with overwork, bullying and lack of control within the workplace.

### 3. Population health and the context of general practice

- DOCLP3.1 Describe the personal health risks of medical practice and the role of maintaining a work-life balance.
- DOCLP3.2 Describe the importance of, and strategies for, negotiating safe working hours.
- DOCLP3.3 Discuss balance between working life and personal relationships.

### 4. Professional and ethical role

- DOCLP4.1 Demonstrate an understanding of the association between maintaining good work performance, workplace satisfaction and reduction of stress.
- DOCLP4.2 Describe the importance of having an independent GP for personal healthcare and how doctors can appropriately access healthcare.
- DOCLP4.3 Describe barriers that may alter your personal access to healthcare, including moving to a new area or commencing a new job.
- DOCLP4.4 Demonstrate that you are meeting your own personal and professional health needs.
- DOCLP4.5 Describe the pitfalls of 'corridor consultations', including how to manage such situations.
- DOCLP4.6 Discuss the role of personal and professional support networks.

### 5. Organisational and legal dimensions

- DOCLP5.1 Describe professional and personal sources of support that exist outside your workplace.
- DOCLP5.2 Describe workplace health and safety issues that need to be considered.
- DOCLP5.3 Describe potential legal issues related to seeking your own healthcare and providing healthcare to doctors.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- DOCLV1.1 Demonstrate an understanding of the special issues around communicating with other doctors, both as a patient and as a treating doctor.

### 2. Applied professional knowledge and skills

- DOCLV2.1 Describe the importance of negotiating basic expectations early in the consultation when treating a doctor-patient including costs, length of appointment, time of appointment and after hours care.

### 3. Population health and the context of general practice

- DOCLV3.1 Describe the ethical responsibilities of interpersonal boundaries in medicine, including sexual boundaries, and describe how impairment with illnesses such as depression can confound these issues.
- DOCLV3.2 Demonstrate how to identify the danger signs of physician impairment.

### 4. Professional and ethical role

- DOCLV4.1 Summarise your own personal, professional crisis plan in the event of illness or other crises.
- DOCLV4.2 Describe your ability to define achievements in your own life while balancing career, life and leisure goals.

### 5. Organisational and legal dimensions

- DOCLV5.1 Describe sources of professional help available for the impaired physician and those who care for them.
- DOCLV5.2 Understand the benefits of medicolegal cover, disability policies, assets protection, superannuation and financial advice.
- DOCLV5.3 Describe time management priorities and strategies for ensuring a healthy lifestyle with a focus on personal preventive healthcare.
- DOCLV5.4 Describe strategies for dealing with stresses related to dealing with bureaucracy, red tape and medicolegal cases.
- DOCLV5.5 Identify the resources available for negotiating pay, working hours and staff relationships.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

DOCLC1.1 Regularly revise the special communication skills required for treating doctors.

### 2. Applied professional knowledge and skills

DOCLC2.1 In the context of taking a thorough history in the routine consultation, describe any doctors' behaviours that can potentially increase their health risks.

DOCLC2.2 Describe the pitfalls in the consultation with a doctor-patient.

DOCLC2.3 Describe appropriate management protocols for a doctor-patient that allow shared decision making while assisting the doctor on the path to better care.

### 3. Population health and the context of general practice

DOCLC3.1 Identify and act on the signs and symptoms of stress before burnout occurs.

DOCLC3.2 Demonstrate processes that ensure up-to-date knowledge of medical board directives on health issues.

### 4. Professional and ethical role

DOCLC4.1 Demonstrate meeting appropriate personal and professional health needs.

DOCLC4.2 Identify a GP who you would be able to seek healthcare from.

DOCLC4.3 Describe processes for mentoring and supporting other doctors and the benefits of role modelling how to access healthcare appropriately.

### 5. Organisational and legal dimensions

DOCLC5.1 Describe the process for regularly reviewing your own medicolegal cover and financial advice to ensure you have the best advice for you and your family.

DOCLC5.2 Describe and review safe practice work including leave; contingency plans for staff illness and after hours rosters, especially in rural and remote areas.

DOCLC5.3 List doctors' health support services.

DOCLC5.4 Describe the procedures necessary to ensure the workplace maximises your personal safety.

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## *Genetics*

### **Contents**

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Definition	125
Curriculum in practice	125
Rationale and general practice context	126
Training outcomes of the five domains of general practice	127
Learning objectives across the GP professional life	129
<i>Medical student</i>	129
<i>Prevocational doctor</i>	130
<i>Vocational registrar</i>	131
<i>Continuing professional development</i>	132
References	133

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## Definition

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General practice genetics deals with the general practice management of hereditary issues, problems and conditions, including those involving the mechanisms of hereditary transmission.

Genetic counselling is a procedure by which patients and their families are given support and advice about the nature and consequences of inherited disorders, the possibility of being affected or having affected children, and the various options available for prevention, diagnosis and management of such conditions.<sup>1</sup>

## Curriculum in practice

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Typical presentations that illustrate how the genetics curriculum applies to general practice include:

- Gary, aged 60 years, has been feeling tired and run down. He says he has been 'putting on a bit of weight' and feels uncomfortable in his upper abdomen, but is more troubled by recent joint swelling and tenderness. He has been a construction worker most of his life and believes this is all part of the aging process. He says: "Even the old fella won't work as well as he used to." Examination identifies hepatomegaly, but you also notice his skin is a grey-bronze colour. What family history might you specifically ask for and what genetic testing would be appropriate?
- Anna, aged 23 years, is planning her first pregnancy. During her pre-conception counselling you discover her younger brother died when he was 16 years of age from complications of cystic fibrosis. Her husband was originally from the Middle East. Does this increase or decrease the risk that their child might be affected? What tests should she be offered prior to and following conception?
- Stephanie, aged 47 years, has a younger sister who has just been diagnosed with breast cancer. Her older brother commenced treatment for prostate cancer 2 years ago. She is now worried about her own risk of developing cancer and is keen to be tested for everything. Assuming she is currently well and her examination is normal, what advice is appropriate for managing her genetic risk?

## Rationale and general practice context

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The last decade has witnessed significant advances in genetic medicine, such as the mapping of the human genome and the understanding of genetic causes of disease.

These advances have increasing relevance to clinical care in general practice including the management of people with a family history of cancer and heart disease, carrier testing for common autosomal recessive conditions, and the diagnosis of inherited diseases such as haemochromatosis and thrombophilia.

### The role of the GP in genetics

Australian<sup>2-4</sup> and international<sup>5-8</sup> studies have highlighted the need for general practitioners to develop genetic literacy and to understand the important role primary care plays in the management of genetic conditions.<sup>9-11</sup> This includes:

- taking and using the family history to determine the risks of common diseases such as cancer and heart disease
- identifying patients with specific genetic conditions who may benefit from referral to genetic counselling or specialist management services
- pre-pregnancy counselling from a genetic perspective, including discussion of prenatal screening and diagnostic tests for genetic conditions
- identifying, assessing and, when appropriate, referring children and adults with developmental delay, developmental disability or dysmorphic features for diagnosis and specialist services
- using genetic tests appropriately, including those listed on the Medicare Benefits Schedule
- being aware of the growing field of genomics and the use of genetic markers to determine therapeutics
- discussing newborn screening programs with parents and managing children who test positive
- supporting families with genetic conditions and co-ordinating their care between clinical genetics services and other clinical specialties.

Genetics can affect many areas of general practice care, and genetic issues may also occur in other curriculum statements.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- GENT1.1 Apply communication strategies (appropriate to those receiving the information), when discussing the implications of a genetic diagnosis or genetic test result, including the implications for family members.
- GENT1.2 Address the potential personal impact of a diagnosis of a genetic condition for the patient and their family.
- GENT1.3 Understand the inherent variation in risk perception and use a range of strategies for communication to support informed decision making.
- GENT1.4 Discuss strategies that the patient may use for communication of genetic risk with other family members.
- GENT1.5 Respect the different belief systems that may have an impact on perceptions of health, disability, kinship and understanding of genetic risk.
- GENT1.6 Communicate sensitively when exploring family relationships, including issues of adoption, paternity and consanguinity.
- GENT1.7 Communicate the implications and limitations of genetic tests and their potential to lead to uncertainty.
- GENT1.8 Recognise and develop strategies to support families in the face of uncertainty or when there is lack of clinical diagnosis.

## 2. Applied professional knowledge and skills

- GENT2.1 Use a three-generation family history to recognise patterns of inherited disease or disability.
- GENT2.2 Use family history information to identify patients who are at increased risk of common, preventable multifactorial conditions.
- GENT2.3 Be aware of the wide range of conditions that may have a genetic factor in their aetiology and the role of disease predisposition genes.
- GENT2.4 Understand the importance of ethnicity in determining risk of certain common inherited conditions.
- GENT2.5 Understand the implications of genetic conditions for other family members who may benefit from genetic counselling.
- GENT2.6 Know the clinical indications for ordering common genetic tests including those on the Medicare Benefits Schedule.
- GENT2.7 Understand the role of genetic tests in the assessment of people with developmental delay, developmental disability and/or dysmorphic features.
- GENT2.8 Know the diagnosis and management of general practice genetic conditions including those described in the NHMRC publication, *Genetics in family medicine: the Australian handbook for general practitioners*.

### 3. Population health and the context of general practice

- GENT3.1 Understand the process of newborn screening, which conditions are included, and be aware of issues relating to retention and access to the newborn screening cards.
- GENT3.2 Discuss the value of pre-pregnancy counselling from a genetic perspective, including discussing prenatal screening and diagnostic tests for genetic conditions and the protective role of folate.
- GENT3.3 Discuss prenatal screening tests that are available in both public and/or private sectors to support informed reproductive choices.
- GENT3.4 Adhere to screening guidelines for genetic conditions as summarised in the RACGP *Guidelines for preventive activities in general practice* (the 'red book').
- GENT3.5 Recognise that genetic conditions are often lifelong, reflective of many issues related to chronic conditions and disability.
- GENT3.6 Be familiar with, and encourage the appropriate use of, community services such as genetic support groups.

### 4. Professional and ethical role

- GENT4.1 Recognise the impact of rapid scientific developments on the ability to provide current information and diagnosis, and the benefits of specialist referral in this context.
- GENT4.2 Be aware of your own values and belief systems and how these may have an impact on patient care when dealing with the implications of a genetic diagnosis, or the result of a genetic test (eg. the decision whether to continue or terminate a pregnancy). Also recognise the need, where necessary, for timely referral to another medical practitioner.
- GENT4.3 Understand the family context of genetic conditions and the ethical issues, including the right of access to and need for consent in the disclosure of genetic risk or genetic test results to blood relatives.
- GENT4.4 Discuss the personal and family implications of third party interest, such as employers and insurers, for a genetic diagnosis in a family member or a predictive genetic test result.
- GENT4.5 Recognise the psychosocial impact of a genetic diagnosis or genetic risk and provide patients with appropriate support or referral.

### 5. Organisational and legal dimensions

- GENT5.1 Discuss the ethical, legal and social implications of common genetic tests.
- GENT5.2 Maintain confidential medical records to include information about genetic conditions and genetic risks.
- GENT5.3 Maintain confidential medical records that adhere to privacy legislation when recording or disclosing information to, or about, other family members.
- GENT5.4 Understand how privacy laws can have an impact on communication about genetic conditions within families.
- GENT5.5 Understand the role of clinical genetics services and how to access them.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- GENLM1.1 Demonstrate sensitivity to the personal beliefs of patients and their family, and the impact this has on a genetic diagnosis and the actions that follow this diagnosis.
- GENLM1.2 Describe how common genetic conditions arise and what their impact might be on the individual and their family.

### 2. Applied professional knowledge and skills

- GENLM2.1 Be able to notate a three-generation family tree and recognise modes of inheritance.
- GENLM2.2 Describe how DNA technology is applied in diagnostic investigations.
- GENLM2.3 Demonstrate a functional understanding of the molecular basis of inheritance and the DNA processes involved in different modes of inheritance.

### 3. Population health and the context of general practice

- GENLM3.1 Describe the importance of gene environment interactions in predisposition to disease and/or disability.

### 4. Professional and ethical role

- GENLM4.1 Describe the ethical and personal issues and privacy implications for the patient, their family and the doctor in genetic diagnosis.

### 5. Organisational and legal dimensions

- GENLM5.1 Describe the role of genetic counselling.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

GENLP1.1 Describe how to undertake pre-pregnancy counselling and advise on available prenatal testing and discuss patient options.

### 2. Applied professional knowledge and skills

GENLP2.1 Demonstrate knowledge of common genetic conditions and the GP's role in the multidisciplinary team that cares for patients with these conditions.

### 3. Population health and the context of general practice

GENLP3.1 Understand the genetic implications in multifactorial common medical conditions.

### 4. Professional and ethical role

GENLP4.1 Demonstrate an awareness of the ethical and personal issues and privacy implications for the patient, their family and the doctor in genetic diagnosis.

### 5. Organisational and legal dimensions

GENLP5.1 Understand the appropriate use of genetic testing and referral for assessment and care by clinical genetic services in the prevocational setting.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- GENLV1.1 Demonstrate the ability to undertake prenatal counselling, recognise complexity and refer accordingly, and support the parents over the consequences of testing.

### 2. Applied professional knowledge and skills

- GENLV2.1 Demonstrate how to recognise and manage the general practice aspect of the care of patients with genetic conditions over time, including considerations of the patient within their family and community.
- GENLV2.2 Describe the implications and consequences of predictive, predisposition testing for later onset disorders.
- GENLV2.3 Outline the diagnosis and management of general practice genetic conditions including those described in the NHMRC publication, *Genetics in family medicine: the Australian handbook for general practitioners*.

### 3. Population health and the context of general practice

- GENLV3.1 Develop and apply practice systems that support routine screening for genetic conditions according to the RACGP 'red book'.

### 4. Professional and ethical role

- GENLV4.1 Manage tensions between the patient with a genetic condition and their right to privacy, the implications for the patient's family, third party interest in the condition, and the doctor's own values and social beliefs.

### 5. Organisational and legal dimensions

- GENLV5.1 Understand the appropriate use of genetic testing and referral for assessment and care by clinical genetic services in the prevocational setting.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

GENLC1.1 Identify gaps in communication skills and attitudes, including genetic counselling in relation to genetic conditions.

### 2. Applied professional knowledge and skills

GENLC2.1 Identify gaps in knowledge, skills and attitudes in relation to genetic conditions including screening and its consequences.

### 3. Population health and the context of general practice

GENLC3.1 Identify gaps in knowledge in relation to population based issues of genetic conditions including screening and its consequences.

### 4. Professional and ethical role

GENLC4.1 Identify and access professional development and resources in the area of genetic conditions and genetic counselling to maintain functional knowledge of this rapidly developing domain.

### 5. Organisational and legal dimensions

GENLC5.1 Maintain and update knowledge of community resources to support patients with genetic conditions, including specialist centres and community support groups.

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## *Men's health*

### **Contents**

---

Definition	137
Curriculum in practice	137
Rationale and general practice context	138
Training outcomes of the five domains of general practice	140
Learning objectives across the GP professional life	142
<i>Medical student</i>	142
<i>Prevocational doctor</i>	143
<i>Vocational registrar</i>	144
<i>Continuing professional development</i>	146
References	147

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

Published by:  
The Royal Australian College of General Practitioners

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## Definition

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Men's health in general practice is defined as the holistic management of health conditions and risks that are most common or specific to men in order to promote optimal physical, emotional and social health in the general practice setting.<sup>1</sup> While male sexual health is important, men's health goes beyond sexual and reproductive health.

## Curriculum in practice

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The following case illustrates how the men's health curriculum applies to general practice:

- Anthony, 43 years of age, is the successful owner of a real estate business. He presents to the practice for a health check following the sudden cardiac death of his elder brother. Anthony's wife Jillian and their children also attend the practice (you know that Jillian has been worried for some time about how hard Anthony has been working). Anthony is considerably heavier than when you last saw him and now weighs 107 kg (height: 173 cm, BMI: 36). He has been working late and eating takeaway food 3 or 4 times a week, usually fried fish and chips or pizza. His alcohol intake has also increased, consuming a six-pack most nights and twice that on Fridays with his workmates. He has been worried at the downturn in the housing market and says the alcohol helps him to relax. He used to be a keen football player until he injured his knee, and knows he needs to exercise more but finds it difficult to get motivated. Anthony had not seen his brother for more than a year, but they were very close and he is tearful in describing the funeral. He has been sleeping poorly and wonders if he might need something to 'help him to just stop thinking about it'.

## Rationale and general practice context

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Australian men are less healthy than Australian women, dying 5 years earlier than their female counterparts,<sup>2</sup> especially in the 25–65 years age group – the main working period of men's lives.

The median age at death of Australian men in 2004 was 79.0 years compared with 83.7 years for women, and this shorter life expectancy occurs when measured across every age group. Men also carry a significantly larger burden of illness and death than women.<sup>2</sup>

General practitioners are well situated to address the specific healthcare needs of men. Good general practice men's healthcare not only includes the management of disease, but involves recognising that major improvements to men's health will be achieved by challenging the way masculinity is defined in Australian culture. This recognises the importance of how boys develop socially, explores ways of taking GPs and health teams to the men who under-attend general practice, as well as addressing the marketing of general practice services to men. Building these links between general practices and the community has the potential to enhance the relationships between men and their GPs.

General practitioners are less likely to see males in patient encounters than females. In 2009–2010, BEACH reported that of 94 386 patient encounters surveyed, 43.1% of patient encounters were males compared with 56.9% females. This was reflected across all age groups except for children aged less than 15 years and was greatest among younger adults (15–24 years and 25–44 years).<sup>3</sup> This low rate of presentation of men across the decades of middle and older age has been linked to men's shorter life expectancy.

Deaths in working age males are more common than in working age females. At age 25 years, male deaths are more than twice as common as female deaths, falling to 1.5 times as common at age 50 years, before beginning to rise again to age 64 years.

Among younger working age males (aged 25–44 years), death is more likely to result from external causes rather than other causes. In 2007, the leading single cause of death for males aged 25–44 years was intentional self harm, accounting for 22.3% of deaths, followed by land accidents (15.3%) and accidental poisoning (9.5%); (26 deaths per 100 000 population) followed by transport accidents (14 per 100 000).<sup>2</sup>

Although called 'working age people', relatively few deaths are formally work related. However, over 90% of work related traumatic injury fatalities are in males, with 30% of these deaths occurring in men aged 55 years or over.<sup>4</sup>

Unhealthy behaviours are also more common in men than women. For example, in 2007–2008, 23.8% of men aged 25–44 years reported daily smoking compared to 19.3% in females and 16.3% of males were found to be more likely to drink daily compared to 11.5% of females.<sup>2</sup> Similarly, 43.2% of males have reported to have used illicit drugs compared to 36.5% of females, and 1.5 million males reported using illicit drugs in the previous 12 months compared to 1.1 million female users. In 2009, 86.3% of cases of newly diagnosed HIV/AIDS cases in Australia were in men.<sup>5</sup>

### Gender in healthcare

Women and men experience health differently. Biological sex differences, such as reproductive health and sexuality, are responsible for health issues traditionally regarded as 'men's health' or 'women's health'.

However, gender refers to the different social and cultural roles, expectations and constraints placed on men and women because of their sex. When analysing the experiences and impacts of health on men and women, differences relating to gender, in addition to biological sex, need to be considered.

Gender differences can influence both women and men's health through:

- exposure to risk factors
- access to, and understanding of, information about disease management, prevention and control
- subjective experience of illness and its social significance
- attitudes toward the maintenance of one's own health and that of other family members

- patterns of service use
- perceptions of quality of care.

Male socialisation and masculinity, social connectedness and work-life balance significantly impact on health. Masculinity has been identified as a key factor leading both men and boys to risk taking and self harming behaviours. Male emotional responses may deny access to the healing effects of emotional release and valuing their own physical, emotional and mental health. Knowledge of the impact of masculinity on health and healthcare is critical to the successful provision of effective general practice care.

Masculine identity and behaviour vary over the course of a man's life and also vary considerably according to cultural and ethnic background, sexual identity, socioeconomic and geographical locations. An understanding of masculine behaviours and notions of maleness should take into account the wide range of masculinities that exist within multicultural Australia. For example: men living in rural and isolated areas, non-Australian born men, Aboriginal and Torres Strait Islander men, older men, men with a disability, men affected by mental illness, war and armed service veterans, and men with other special needs such as divorced and separated men who may, or may not, be primary carers.

The health of Aboriginal and Torres Strait Islander men is worse than any other subgroup in Australia. Excess morbidity and mortality relates to unemployment, poverty, incarceration and low self esteem. For the period 2007–2008 life expectancy for Aboriginal and Torres Strait Islander men was estimated to be approximately 12 years less than their nonindigenous counterparts.<sup>2</sup>

Men are more likely to be both the perpetrators of violence and its victims. Violence is a significant health issue for Australian men for many reasons including the effect on victims, the health impacts of imprisonment on perpetrators and the deleterious effects on healthy relationships.

Males are responsible for the vast majority of cases of domestic violence and GPs have a responsibility to deal with its effects. Exposure of boys to violence during their formative years contributes to a range of issues including homelessness, drug use, depression, relationship difficulties and perpetuation of the cycle of violence later in their lives.

In addition to the clinic, GPs may become involved in community activities where men congregate to provide services, heighten the awareness of men's health issues and act as advocates for male patients.

## Male health promotion in Australian: the National Male Health Policy

The Australian National Men's Health Policy<sup>6</sup> was released in 2010. This policy encourages all males to take individual action to improve their own health as well as focusing on appropriate government action, cross-sectorial activity, and initiatives that can be undertaken by the health system and community to improve the health of Australian males.

To achieve this, the policy identified six priority outcomes for improving the health of Australian males:

- optimising health outcomes
- working towards health equity between population groups of males
- working towards health equity between males at different life stages
- focusing on preventive health for males
- building a strong evidence base on male health
- access to healthcare for males.

General practitioners are already involved in many of these activities and familiarity with the policy helps to guide men's healthcare in primary care.

## Related curriculum areas

- *Population and public health* regarding health promotion programs
- *Philosophy and foundation of general practice* for general consultation issues
- *Mental health* for the general mental health issues that affect men
- *Multicultural health* for successful cross cultural communication including the correct use of translators.

## Training outcomes of the five domains of general practice

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### Communication skills and the patient-doctor relationship

- MENT1.1 Recognise that men are less likely than women to discuss their health problems with their GP for emotional, cultural and gender related reasons.
- MENT1.2 Communicate nonjudgmentally to help reduce any embarrassment or emotional difficulties when attending for treatment.
- MENT1.3 Focus on communication strategies to help improve the ability of male patients to disclose their health concerns. This may include detecting whether a male patient prefers to see a male doctor.
- MENT1.4 Recognise the particular patient-doctor communication challenges when younger men attend for treatment.

### Applied professional knowledge and skills

- MENT2.1 Recognise that men may be dismissive of their own risks and health problems.
- MENT2.2 Understand key male medical problems and lifestyle risks throughout the entire male lifecycle including men's mental health and wellbeing.
- MENT2.3 Educate men about how their body functions and their special health needs, especially the link between lifestyle risks and disease.
- MENT2.4 Understand the role of men in the family and the workplace.
- MENT2.5 Understand the problems caused by unemployment among men and how this is critical to successful healthcare.
- MENT2.6 Manage the primary care presentation of male genitourinary problems. Must be aware of potential genitourinary emergencies such as testicular torsion and penile injuries.

### Population health and the context of general practice

- MENT3.1 Incorporate the range of key medical conditions and lifestyle risk factors affecting men in order to successfully promote men's health needs.
- MENT3.2 Have knowledge of the conditions affecting men at each age, which helps identify key health promotion issues and opportunities, including relevant government men's health programs and policies.
- MENT3.3 Understand the impact of demographic factors, such as socioeconomic status and ethnicity, which helps target health promotion activities. This includes:
  - MENT3.3.1 men living in rural and isolated areas
  - MENT3.3.2 non-Australian born men
  - MENT3.3.3 Aboriginal and Torres Strait Islander men
  - MENT3.3.4 older men
  - MENT3.3.5 men who have sex with men
  - MENT3.3.6 men with mental illness
  - MENT3.3.7 men with a disability
  - MENT3.3.8 other special needs.
- MENT3.4 Recognise that circumcision is important for some religious beliefs.
- MENT3.5 Maintain skills in men's health promotion, especially in controversial areas such as prostate cancer screening where up-to-date knowledge and skilful counselling may be required to help patients reach informed decisions.

## Professional and ethical role

- MENT4.1 Identify when a male patient may prefer to see a male doctor, respect this choice and arrange when practical.
- MENT4.2 Recognise that men are more likely to be involved in a range of activities that involve the law and GPs may need to adapt their management appropriately. These include accidental or self inflicted injury, work related injuries and incidents and violence including partner abuse.

## Organisational and legal dimensions

- MENT5.1 Evaluate the practice's effectiveness in providing men's health services including incorporating routine opportunistic health promotion into male patient consultations, especially for those patients who do not attend regularly.
- MENT5.2 Create male friendly environments. For example use men's health posters and displays of information relating to men, provide evening clinics or appointment schedules that accommodate working shifts or commuting over distances, promote a front-of-office culture, which acknowledges men's problems with appointments and waiting times. Provide as broad a range of services as possible, either in the practice or via co-operative arrangements with other local providers.
- MENT5.3 Offer services, where appropriate, in areas where men congregate such as sporting facilities, in workplaces or entertainment areas. Seek to co-ordinate and co-operate with existing general practices and other health service providers.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- MENLM1.1 Identify why men may be less likely to discuss their health problems with healthcare providers.
- MENLM1.2 Discuss the need for nonjudgmental communication with male patients.

### 2. Applied professional knowledge and skills

- MENLM2.1 Describe the clinical characteristics of common male specific health conditions and risks in Australia and relate these to each part of the male lifecycle.
- MENLM2.2 Describe the impact of gender on lifestyle related diseases.
- MENLM2.3 Describe and discuss the demographic diversity that exists within male patients and the affect on masculinity and health. This includes men in rural and isolated areas, non-Australian born men, Aboriginal and Torres Strait Islander men, older men, men who have sex with men, and men with a disability, mental illness or other special needs.
- MENLM2.4 Describe the presentation of male sexual health emergencies such as testicular torsion.
- MENLM2.5 Discuss the social construction of masculinities, eg. how boys are raised compared to girls and the effect of cultural attitudes on the social development of boys.
- MENLM2.6 Summarise the psychosocial and health impacts caused by male unemployment.

### 3. Population health and the context of general practice

- MENLM3.1 Describe the epidemiology of common male specific health conditions and risks in Australia and relate them to each part of the male lifecycle.
- MENLM3.2 Describe men's health priorities in Australia.
- MENLM3.3 Describe the importance of male circumcision for certain religious groups in Australia.

### 4. Professional and ethical role

- MENLM4.1 Examine the reasons and ethics when a male patient chooses only to see a male doctor.
- MENLM4.2 Discuss the impact of male socially constructed attitudes, values and behaviours on their emotional, physiological and physical health and their social relationships.
- MENLM4.3 Understand and support the changes required to make the healthcare system and general practice more responsive to men's needs.

### 5. Organisational and legal dimensions

- MENLM5.1 Examine barriers that men may experience when accessing general practice services, especially young men.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- MENLP1.1 Outline how men may not perceive or discuss their own health risks.
- MENLP1.2 Explain to patients how common illnesses and presentations are related to lifestyle factors, especially for smoking, nutrition, alcohol and physical activity.

### 2. Applied professional knowledge and skills

- MENLP2.1 Identify situations where men may use healthcare less commonly than women, but may still have significant morbidity and risk behaviours.
- MENLP2.2 Identify occupational conditions more common in men such as deafness, back problems, stress and injury.
- MENLP2.3 Identify important testicular or penile emergencies such as testicular torsion or paraphimosis.
- MENLP2.4 Demonstrate the ability to catheterise a male patient.

### 3. Population health and the context of general practice

- MENLP3.1 Identify the effects of male violence (to self and others) in the consultation.
- MENLP3.2 Describe the differences in men's health according to social, cultural and economic factors.

### 4. Professional and ethical role

- MENLP4.1 Demonstrate a nonjudgmental approach to patients and their lifestyle choices.
- MENLP4.2 Counsel patients about the need for testing for infectious diseases, including the need for disease notification of a positive test.
- MENLP3.3 Discuss community attitudes toward sexual violence, the characteristics of perpetrators and myths about violent acts.

### 5. Organisational and legal dimensions

- MENLP5.1 Identify when a male patient may choose to see only a male doctor.
- MENLP5.2 Identify that men from different cultures may respond to health services differently.
- MENLP5.3 Comply with the legal provisions that protect at risk persons. For example, legal rulings restricting behaviour (including restraining and apprehended violence orders, reporting to police for criminal activities), sexually transmissible infection notification regulations and contact tracing.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- MENLV1.1 Demonstrate the ability to listen to and understand the needs of male patients.
- MENLV1.2 Identify strategies for overcoming male specific barriers to patient-doctor communication.
- MENLV1.3 Promote the importance of sensitively discussing sexuality and other intimate issues to assist men to make positive health changes.
- MENLV1.4 Use empathy and supportive strategies to assist male patients to show emotions and express needs.
- MENLV1.5 Demonstrate the ability to develop a partnership with male patients to enable them to understand how behaviours, attitudes and values cause health problems.

### 2. Applied professional knowledge and skills

- MENLV2.1 Take a sexual history and perform male specific basic procedural skills and treatments.
- MENLV2.2 Demonstrate an ability to counsel male patients about their health risks, especially those detailed in the RACGP *Population health guide to behavioural risk factors in general practice* (SNAP).
- MENLV2.3 Demonstrate an ability to counsel men on the advantages and disadvantages of prostate cancer screening.
- MENLV2.4 Outline sexually transmissible infection and HIV/AIDS screening protocols including antibody testing and management.
- MENLV2.5 Describe support systems for those caring for a person in the final stages of AIDS.

### 3. Population health and the context of general practice

- MENLV3.1 Demonstrate how to provide evidence based opportunistic health promotion and disease prevention for men in general practice.
- MENLV3.2 Use evidence based health promotion strategies to reduce the over representation of men with cardiovascular disease, cancer, injuries, suicide and violence related issues.
- MENLV3.3 Outline harm minimisation strategies, interventions and therapeutic programs for men such as preventing and minimising violence, hazardous drinking and self harm.
- MENLV3.4 Understand how the National Men's Health Policy relates to general practice and how it influences funding for men's healthcare.

## 4. Professional and ethical role

- MENLV4.1 Educate men proactively on the relationship between lifestyle and health.
- MENLV4.2 Reflect on own attitudes about masculinity, sexuality, sexual behaviours and violence and how this affects relationships with patients, their families and victims.

## 5. Organisational and legal dimensions

- MENLV5.1 Identify men who attend the practice less frequently as an opportunity for lifestyle risk assessment and health promotion.
- MENLV5.2 Describe specific Medicare items that can be used to promote the health of men.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- MENLC1.1 Review the communication skills required for effective delivery of men's healthcare in general practice.

### 2. Applied professional knowledge and skills

- MENLC2.1 Monitor changes in knowledge in men's health conditions, especially prostate cancer health promotion issues.
- MENLC2.2 Consider, where appropriate, how to incorporate the practice of men's healthcare into the training of medical practitioners and other healthcare workers and stakeholders.

### 3. Population health and the context of general practice

- MENLC3.1 Implement population based approaches to men's health needs in the general practice setting.
- MENLC3.2 Consider participating in outreach and community based men's health initiatives.

### 4. Professional and ethical role

- MENLC4.1 Describe how GPs can act as an advocate for men's health needs, especially in the local community.
- MENLC4.2 Identify and, where appropriate, network with professional organisations that seek to promote policy, program and funding change for men's health.

### 5. Organisational and legal dimensions

- MENLC5.1 Review how effective general practice is in the delivery of men's health services.
- MENLC5.2 Demonstrate familiarity with local support services, networks and groups for men and encourage their use.
- MENLC5.3 Describe how to make your general practice more sensitive to the health needs of men.
- MENLC5.4 Describe how specific Medicare items are incorporated into your practice's promotion of men's health.

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## *Multicultural health*

### Contents

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Definition	151
Curriculum in practice	152
Rationale and general practice context	153
Training outcomes of the five domains of general practice	155
Learning objectives across the GP professional life	158
<i>Medical student</i>	158
<i>Prevocational doctor</i>	160
<i>Vocational registrar</i>	162
<i>Continuing professional development</i>	164
References	165

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## Definition

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Multicultural health in Australian general practice reflects how the core principles of multiculturalism operate within the context of general practice, including ensuring that the training of general practitioners has a strong and specific emphasis on building cultural competence and effectiveness, that is, the ability to work competently and effectively in a culturally diverse workplace and in encounters with people from different cultural backgrounds to ensure the delivery of high quality general practice care.

The concept of multiculturalism in Australia is based on the principles of pluralism, which recognises, accepts and respects the rights of all Australians to express and share their individual cultural heritage within an overriding commitment to Australia, its people and the basic structures and values of Australian society. The key to Australian multiculturalism is inclusivity rather than division, with Australia's multicultural composition being 'at the heart of our national identity and intrinsic to our history and character'.<sup>1</sup>

Terms often used within discussions of multicultural health include:

**NESB:** Non-English speaking background (NESB) is used most frequently to describe people who were born in a country where the predominant language is not English. They are first generation NESB. Their children are second generation NESB.

**CALD:** Culturally and linguistically diverse (CALD) refers to the wide range of cultural groups that make up the Australian population and Australian communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. The term 'culturally and linguistically diverse background' is used to reflect intergenerational and contextual issues, not only migrant experience.<sup>1</sup>

Culturally and linguistically diverse background is a term used in policy documents but is often poorly defined. The term is commonly used to refer to people living within culturally diverse communities in Australia that may differ from the mainstream dominant culture.

Specific general practice issues affecting people from culturally and linguistically diverse backgrounds in Australia are many and diverse. They include providing high quality, culturally relevant, appropriate and accessible services and information, recognising the potential for discrimination in services targeted toward mainstream dominant culture being inappropriate for people of different cultural and linguistic backgrounds; using language services to best effect and the specific needs of different communities; and promoting the benefits of a culturally diverse community. These are only a few examples of the many complex issues that impact on people from culturally and linguistically diverse backgrounds and Australian general practice.

**Ethnic:** This term is no longer favoured and is not officially used in some states and territories of Australia. It is largely understood to refer to people born in a non-English speaking country or whose parents were born in a non-English speaking country.

**Ethnicity:** This term refers to geographical and cultural origins, which are sometimes used when referring to specific conditions, eg. beta-thalassaemia is more common in Australian people of Greek ethnicity or background.

Multicultural health recognises that the issues addressed in this curriculum are interconnected with many but not all indigenous health issues. Even so, users of this curriculum statement should not apply it directly in developing teaching and training materials for Aboriginal and Torres Strait Islander health, but instead should refer to the specific curriculum statement on Aboriginal and Torres Strait Islander health.

## Curriculum in practice

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The following case illustrates how the multicultural health curriculum applies to general practice:

- Charuni, 28 years of age, has recently arrived from Sudan. She presents looking sweaty and unwell. Her husband Hasan has accompanied her as he is the only family member who speaks English, but he clearly appears uncomfortable and keeps his face averted. It transpires her problem has to do with pain and fever and something relating to 'women's troubles'. How will you proceed?

## Rationale and general practice context

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A patient's presentation of illness is influenced by culture. The GP needs to understand how the cultural background of both the doctor and the patient influences the general practice consultation. Multicultural health in Australian general practice involves making a holistic assessment of the patient's needs and recognising the impact of cultural issues in the Australian environment.

Every individual constructs the meaning of their experience of health from within their cultural background. The social group in which we live influences our interpretation of the meaning of our experience of health and illness and affects our understanding of what symptoms are significant. Cultures help determine the behaviours we use when presenting to the GP.

The development of cultural competence is an integral skill in general practice.

Cultural competence<sup>2</sup> is a set of congruent behaviours, attitudes and policies that come together in a system, agency or health service, or among professionals, which enable the organisation or those professionals to work effectively in cross cultural situations.

Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating the understanding and appreciation of different cultures. To become more culturally competent, a health service or professional or system needs to:

- value diversity
- have the capacity for cultural self assessment
- be conscious of the dynamics that occur when cultures interact
- institutionalise cultural knowledge
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures.

This involves challenging practitioner cultural assumptions, developing empathy for patients and colleagues with a different worldview, and developing the necessary skills to ensure that appropriate communication and interaction occurs within the consultation to result in quality care.

## Multicultural health issues impacting on general practice

Multicultural health issues can present challenges to providing quality primary care and GPs are in a strong position to be advocates to improve the health of people from culturally and linguistically diverse backgrounds.

Australia's society is linguistically and culturally diverse, consisting of about 3% of Australians being of indigenous origin, while 97% have settled or are descendants of settlers over the past 200 years.<sup>3</sup>

Since 1945, 7 million people have migrated to Australia and 1 in 4 of Australia's 22 million people were born overseas. Australians speak over 260 languages and identify with more than 270 ancestries.<sup>1</sup>

Multicultural diversity in Australia is increasing. In 2001, 23.1% of people living in Australia were born overseas compared to 14.35% in 1991. Those born in the United Kingdom (5.6%) and Europe (11.6%) have been decreasing but those born in east, central or southern Asia (6.0%) have been increasing over the past 10 years.<sup>4</sup> Around 44% were born overseas or have a parent who was born overseas. Four million people (over 25%) speak a language other than English at home.<sup>1</sup>

Issues in multicultural health in Australian general practice are complex and exist at every level of the health system, community and individual social environments. These issues include:

- Access to healthcare – patients from a culturally and linguistically diverse background may find they have specific problems accessing healthcare. Poverty, poor education and difficulty with transport are likely to impact health opportunities for those from a culturally and linguistically diverse background. In addition to these well documented social determinants of health, those from a culturally and linguistically diverse background may not be aware of the care available in the community and may not be able to access what is readily available because of language, religion or other cultural barriers.
- Equity of healthcare access is important for all Australians and is difficult to achieve when access issues are not addressed. As well as these issues, some patients from a culturally and linguistically diverse background experience discrimination from the healthcare system due to their country of origin, cultural background and religious beliefs. Healthcare professionals need to recognise this potential and be prepared to advocate for their patients when necessary to ensure adequate care. Social discrimination in health is experienced by many people from a culturally and linguistically diverse background, as well as inequality in employment, education and other areas.
- Language difficulties can negatively impact upon the care received by those from a culturally and linguistically diverse background. Over 200 languages are spoken in Australia, and in addition, nonverbal communication, communication styles, use of family or a third person for communication support and differing understandings of English words and phrases can all impact on clinical care. Different cultures attach different meanings to parts of the body and types of illness, and this can impact upon the presentation of the illness or compliance with treatment.
- Culture encompasses many issues. There are significant cultural differences even between people who speak the same language or come from the same country. Cultural issues that need to be considered are:
  - cultural lens:<sup>5</sup> each person, including health professionals, needs to recognise that they have their own unique personal worldview influenced by the cultures that nurtured them. This ‘cultural lens’ may influence the way a health professional may judge and make assumptions about patients from a different background, and recognising this cultural bias is a necessary step for clinical effectiveness. A patient’s cultural lens shapes beliefs about illness causation, the nature of a particular illness, and the appropriate treatment and expected outcome
  - diversity within diversity: within each culture group there may be differences in ideas about age, gender, sexuality and social issues. General practice care needs to acknowledge this diversity in its provision of healthcare
  - religious issues: can alter the management of a patient. Religion can determine the patient’s and healthcare provider’s worldview and has a major influence over a person’s life, lifestyle and understanding of illness. It may affect diet and use of medications. All major religions are represented in Australia.

Multicultural health in general practice involves tackling health inequalities and reducing barriers to accessing general practice care.

The GP also has a role to play in breaking down cultural stereotypes through the provision of high quality care for all people from culturally and linguistically diverse backgrounds.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- MCHT1.1 Communicate with cultural competence.
- MCHT1.2 Understand how language difficulties complicate communication during the consultation, making an appointment, phoning for emergency care and reading health information.
- MCHT1.3 Understand that even when a patient speaks English, lack of English proficiency can cause communication problems, resulting in potentially serious medical situations. These may include not understanding how to take medications, subtle misunderstandings that can be critical in emotionally charged issues, and mental health issues and cultural assumptions.
- MCHT1.4 Use interpreters skilfully and effectively to help avoid potential problems encountered during interpreted consultations. This includes working with face-to-face and telephone interpreters and understanding how the gender and background of the interpreter may influence the interaction, eg. when discussing women's health, sexual health or other sensitive matters.
- MCHT1.5 Understand the importance of directing the conversation to the patient during the interpreted consultation and not to the interpreter.
- MCHT1.6 Ensure confidentiality, especially in small communities, and beware of the pitfalls of using families in this role.
- MCHT1.7 Understand how a lack of awareness of culturally specific religious needs, beliefs and practices may impede addressing specific cultural issues, such as female genital mutilation, domestic violence and sexual violence, as well as potentially offending patients.
- MCHT1.8 Be aware of the risk of mental health issues in culturally and linguistically diverse communities, which may result from trauma, torture, social isolation and language isolation, and how these may also impact on effective communication.
- MCHT1.9 Be aware of and use, where appropriate, relevant written materials.
- MCHT1.10 Understand how educational background and literacy levels may be difficult to assess when there is a language barrier.
- MCHT1.11 Understand that the relevance of educational materials will vary for each individual, eg. some people speak one language but read in another – this will have implications when determining which resources are appropriate for the patient.
- MCHT1.12 Be aware of the impact of a patient's own cultural lens. This includes beliefs about disease, health and healthcare; the impact of faith and religious beliefs; and pharmacology differences in different ethnicities.

## 2. Applied professional knowledge and skills

- MCHT2.1 Learn about illnesses that may not be common within the general community but occur among those from culturally and linguistically diverse backgrounds.
- MCHT2.2 Understand how social and environmental determinants of health influence quality multicultural general practice care, including:
  - MCHT2.2.1 diseases from the country of origin of the patient – nutritional deficiencies; health effects of war, torture and trauma; infectious diseases

- MCHT2.2.2 diseases relating to migration; refugees may spend many years transiting countries
- MCHT2.2.3 diseases of settlement – nutrition and lifestyle diseases of host country
- MCHT2.2.4 mental health including conditions related to patients' pre-migration experiences of loss, torture and trauma; difficulties associated with settling into a new country; cultural stigma of mental illness
- MCHT2.2.5 specific diseases common to certain populations such as thalassaemia, sickle cell anaemia, haemochromatosis
- MCHT2.2.6 culturally specific practices such as female genital mutilation/cutting.
- MCHT2.3 Understand how the social, linguistic and cultural isolation commonly experienced by patients from a culturally and linguistically diverse background has the potential to escalate minor health problems into serious health concerns.
- MCHT2.4 Recognise there may be limited evidence related to the conditions encountered. An innovative approach may be needed, including relying on specialist multicultural agencies for advice and accessing online information.
- MCHT2.5 Understand the barriers that may limit access for culturally and linguistically diverse people, including refugees, such as individual health patient issues, complexity of family structures and health issues related to their communities, and adjusting to and having ongoing access to the Australian health system.
- MCHT2.6 Understand how a holistic approach helps address multicultural health including attention to factors at the level of the:
  - MCHT2.6.1 individual – physical and emotional dimensions
  - MCHT2.6.2 family – social and relationship dimensions
  - MCHT2.6.3 community – cultural and political dimensions.
- MCHT2.7 Tolerate ambiguity, suspend judgment and develop empathy when meeting the health needs of patients from different cultures.
- MCHT2.8 Be prepared to deal with culturally specific conditions despite the lack of evidence based information for some problems faced within culturally and linguistically diverse communities.

### 3. Population health and the context of general practice

- MCHT3.1 Understand how language barriers and cultural acceptability are potential major barriers to accessing specific services such as breast screening, Pap tests, palliative care and immunisation.
- MCHT3.2 Understand how the experiences of people from culturally and linguistically diverse backgrounds in accessing healthcare in their country of origin can impact on their access to healthcare in Australia.
- MCHT3.3 Understand how the Australian health system has been set up for the majority culture, which may be culturally very different from some culturally and linguistically diverse communities.
- MCHT3.4 Understand how population health risks can change with time and acculturation and can impact upon subsequent generations.

### 4. Professional and ethical role

- MCHT4.1 Be aware of how a clinician's personal cultural beliefs and attitudes affect their management of patients from culturally and linguistically diverse backgrounds. Medical practitioners in many countries have been involved in the torture of political

detainees and this means the trust usually considered inherent within the patient-doctor relationship cannot be assumed, and therefore needs to be established.

- MCHT4.2 Respect and address any specific patient concerns about accessing services in a large government hospital if they had negative experiences in hospital in the country they left.
- MCHT4.3 Understand how important professional issues may be experienced or perceived differently by people from culturally and linguistically diverse backgrounds including:
  - MCHT4.3.1 privacy and confidentiality
  - MCHT4.3.2 informed consent
  - MCHT4.3.3 autonomy and adherence to treatment and treatment plans
  - MCHT4.3.4 equality and partnership in management.

## 5. Organisation and legal dimensions

- MCHT5.1 Record necessary cultural information within the medical records in a culturally sensitive manner that still enables others within the practice to access the relevant information needed to enhance a patient's care.
- MCHT5.2 Engage within and beyond medical settings to enhance a practice's ability to care for these communities.
- MCHT5.3 Access patient health information in different languages.
- MCHT5.4 Ensure practice services are accessible and appropriate for family groups and culturally diverse populations.
- MCHT5.5 Ensure systems are in place for efficient access to face-to-face and telephone interpreters before and during consultations.
- MCHT5.6 Know how to gain access to interpreter services for routine and emergency consultations and be aware of the costs.
- MCHT5.7 Ensure appropriate opportunities are available for training to ensure effective service delivery to culturally and linguistically diverse background patients.
- MCHT 5.8 Know the legal issues related to consent when the patient is not proficient in the English language.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- MCHLM1.1 Describe common challenges in cross cultural communication – trust, rapport, verbal and nonverbal cues and style.
- MCHLM1.2 Outline the importance of curiosity, empathy and respect in patient care.
- MCHLM1.3 Describe models of effective cross cultural communication, assessment and negotiation and how this impacts on illness.
- MCHLM1.4 Describe the function of the interpreter in the medical interview and list effective ways of working with interpreters.
- MCHLM1.5 Elicit a cultural, social and medical history, including patients' health beliefs and explanatory models of their illness.

### 2. Applied professional knowledge and skills

- MCHLM2.1 Define contemporary and accepted terms in multicultural health such as ethnicity, race, culture, NESB, cultural and linguistic diversity and their implications on healthcare.
- MCHLM2.2 Describe Australian patterns of multicultural health within a worldwide immigration context.
- MCHLM2.3 List prevalent health problems in culturally and linguistically diverse communities in Australia and how these differ from the general Australian population.
- MCHLM2.4 Discuss how cultural issues are integral in the medical interview and in providing healthcare.
- MCHLM2.5 Describe the challenges related to linguistic diversity in healthcare.

### 3. Population health and the context of general practice

- MCHLM3.1 Understand the population health issues related to those from a culturally and linguistically diverse background.
- MCHLM3.2 Understand that the pattern of health among specific groups from a culturally and linguistically diverse background may initially reflect patterns of the country of origin and that these patterns can change following migration, settlement and acculturation.
- MCHLM3.3 Identify reasons for intra and intergroup difference in health experiences of culturally and linguistically diverse communities and have an awareness of how to describe the diversity that occurs within specific culturally and linguistically diverse communities.
- MCHLM3.4 Describe the social and environmental determinants of health in relation to people from culturally and linguistically diverse communities – education, employment, socioeconomic status, housing, culture, gender.
- MCHLM3.5 Understand how those from culturally and linguistically diverse communities may experience health issues differently because of their language, religious and cultural beliefs.

- MCHLM3.6 List the sociocultural and environmental determinants of health that are applicable to people from culturally and linguistically diverse backgrounds.
- MCHLM3.7 Outline the epidemiology and demographics of culturally and linguistically diverse communities in Australia.

#### 4. Professional and ethical role

- MCHLM4.1 Reflect and describe your own (ie. the medical student's) cultural background and biases and how this shapes your own cultural lens.
- MCHLM4.2 Discuss the ethical principles of patient centred care.

#### 5. Organisational and legal dimensions

- MCHLM5.1 Outline when approaches to the assessment and management of a patient from a culturally and linguistically diverse background are the same as those of patients of mainstream culture, and where they may differ, eg. in the use of interpreters and being aware of culturally different health beliefs and expectations.

# Learning objectives across the GP working life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- MCHLP1.1 Use negotiation and problem solving skills in shared decision making with patients from culturally and linguistically diverse backgrounds.
- MCHLP1.2 Assess and enhance patient adherence based on patients' explanatory model of health and illness.
- MCHLP1.3 Apply models of effective cross cultural communication in consultations.
- MCHLP1.4 Identify when an interpreter is required and work with the interpreters effectively both face-to-face and over the telephone.
- MCHLP1.5 Describe the inherent power imbalance between doctor and patient and how this may affect the clinical encounter.
- MCHLP1.6 Be aware of referral agencies and resources that may be useful in communication with and education of patients from culturally and linguistically diverse backgrounds.
- MCHLP1.7 Demonstrate respect for a patient's culture and health beliefs.

### 2. Applied professional knowledge and skills

- MCHLP2.1 Identify how factors in multicultural health (eg. culture, cultural and linguistic diversity) affect healthcare quality, access, cost and outcomes.
- MCHLP2.2 Outline how patients' and their families' healing traditions, beliefs and cultural beliefs may affect their healthcare.
- MCHLP2.3 Assess and manage common health problems of culturally and linguistically diverse communities, including refugees.

### 3. Population health and the context of general practice

- MCHLP3.1 Describe systemic factors other than biomedical, such as historical, political, social, environmental and institutional, which impact on health and healthcare disparities.
- MCHLP3.2 Describe the epidemiology of culturally and linguistically diverse communities in Australia including recently arrived refugees.
- MCHLP3.3 Discuss the public health implications of government policy on refugees and asylum seekers.
- MCHLP3.4 List relevant and appropriate public and private community resources that patients from culturally and linguistically diverse background can access.
- MCHLP3.5 Discuss the historical and political impact of discrimination on health and healthcare for people from culturally and linguistically diverse backgrounds.
- MCHLP3.6 List strategies used to address prevalent public health issues in culturally and linguistically diverse communities.
- MCHLP3.7 Discuss barriers to eliminating health disparities.

## 4. Professional and ethical role

- MCHLP4.1 Identify how your (ie. the doctor's) own cultural background and biases (cultural lens) may impact healthcare delivery to culturally and linguistically diverse communities.
- MCHLP4.2 Apply ethical principles to the care of patients from culturally and linguistically diverse backgrounds in an appropriate and sensitive way, knowing that there may be differences in values.
- MCHLP4.3 Outline the role of the health professional as an advocate for patients from culturally and linguistically diverse communities.

## 5. Organisational and legal dimensions

- MCHLP5.1 Identify strategies used in hospitals to reduce risks and adverse events to patients from culturally and linguistically diverse backgrounds.
- MCHLP5.2 Discuss the legal issues related to some cultural practices (eg. female genital mutilation/cutting).

# Learning objectives across the GP working life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- MCHLV1.1 Outline the possible implications of the patient's use of English as a second language on their health, treatment and compliance.
- MCHLV1.2 Communicate effectively and sensitively with patients from different cultures.
- MCHLV1.3 Identify the need to provide gender specific health education, which takes into account cultural and gender attitudes, gender power and appropriate examination procedures.
- MCHLV1.4 In assessing people from culturally and linguistically diverse backgrounds, recognise the need for interpreters and know how to access and utilise different types of interpreting services.
- MCHLV1.5 Recognise and manage the impact of bias, class and power in consultations.
- MCHLV1.6 Utilise referral agencies and resources that may be useful in communication with and education of patients from culturally and linguistically diverse backgrounds.
- MCHLV1.7 Apply strategies for overcoming critical communication barriers to the diagnosis and management of health problems.

### 2. Applied professional knowledge and skills

- MCHLV2.1 Outline the health related issues specific to pre-migration, migration, settlement, ethnicity and culture.
- MCHLV2.2 Identify cultural groups that are potentially torture and trauma sufferers, recognise the common presenting symptoms, outline the screening of these common problems and outline appropriate management strategies.
- MCHLV2.3 Identify strategies to overcome low usage of specific services and preventive activities.
- MCHLV2.4 Assess and manage health issues of recently arrived refugees, including screening for common nutritional deficiencies, infectious disease, mental health problems, catch up immunisation, preventive screening and dental and specialist referral as appropriate.
- MCHLV2.5 Outline strategies for the management of culture specific issues that affect health, eg. late presentation of illness and problems with treatment concordance.

### 3. Population health and the context of general practice

- MCHLV3.1 Discuss the cultural, language, social, economic, emotional, biological and political issues that can potentially affect the health of culturally and linguistically diverse communities:
  - MCHLV3.1.1 diseases from the country of origin of the patient, eg. nutritional deficiencies; health effects of war, torture and trauma; infectious diseases; and any neglected chronic conditions
  - MCHLV3.1.2 diseases relating to migration process, including refugee health
  - MCHLV3.1.3 diseases of settlement (eg. diet and lifestyle related diseases of host country)

- MCHLV3.1.4 mental health – including depression, anxiety, post-traumatic stress disorder, torture and trauma related conditions. Describe the impact of stigma and of differing cultural understandings of mental health problems
- MCHLV3.1.5 specific diseases common to certain populations such as thalassaemia, sickle cell anaemia, haemochromatosis
- MCHLV3.1.6 culturally specific practices such as female genital mutilation – it is important to include women's health as a whole, including contraception, antenatal and obstetric issues, as well as female genital mutilation/cutting
- MCHLV3.1.7 the conditions that are screened for prior to migration and which conditions need follow up after arrival.
- MCHLV3.2 List relevant public health issues of people coming from a culturally and linguistically diverse background.
- MCHLV3.3 Identify local and relevant services in the mainstream and those specifically for people from culturally and linguistically diverse backgrounds to improve equity of access, including refugee services.
- MCHLV3.4 Apply a holistic approach to health assessment and management of culturally and linguistically diverse patients.

## 4. Professional and ethical role

- MCHLV4.1 List strategies to deal with potential effects of personal cultural experiences, beliefs and behaviour on the outcome of consultations with patients from culturally and linguistically diverse backgrounds.
- MCHLV4.2 Outline how different cultural views impact on legal and ethical aspects of healthcare and health service.
- MCHLV4.3 Identify strategies to act as an advocate for people from culturally and linguistically diverse backgrounds in the multidisciplinary care environment and in negotiating secondary and tertiary care.
- MCHLV4.4 Identify the political climate that you live and work in to help your effectiveness in delivering appropriate healthcare to culturally and linguistically diverse communities, including recently arrived refugees.
- MCHLV4.5 Describe the good medical practice guidelines of the Medical Board of Australia and how they relate to multicultural health.

## 5. Organisational and legal dimensions

- MCHLV5.1 Outline how to identify, and the importance of appropriately recording, culturally and linguistically diverse background and refugee status.
- MCHLV5.2 Describe the impact on practices servicing the needs of culturally and linguistically diverse patients and newly arrived refugees.
- MCHLV5.3 Identify strategies used in general practice to reduce risks and adverse events for patients from culturally and linguistically diverse backgrounds, including refugees.
- MCHLV5.4 Identify strategies for the efficient and effective use of interpreting services.
- MCHLV5.5 Outline strategies to improve follow up and recall of patients from culturally and linguistically diverse backgrounds, including refugees.
- MCHLV5.6 Identify practice systems required to access relevant health and healthcare information to aid in the assessment and management of patients from culturally and linguistically diverse communities, including refugees.

# Learning objectives across the GP working life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- MCHLC1.1 Actively seek to identify gaps in the knowledge, skills and attitudes to communicating effectively with people from culturally and linguistically diverse backgrounds.

### 2. Applied professional knowledge and skills

- MCHLC2.1 Actively seek to identify gaps in their knowledge, skills and attitudes to cultural competence and health disparities for culturally and linguistically diverse communities.

### 3. Population health and the context of general practice

- MCHLC3.1 Keep up-to-date with changes in the field of multicultural health and the needs of local culturally and linguistically diverse communities.
- MCHLC3.2 List strategies to improve access for patients from culturally and linguistically diverse backgrounds.
- MCHLC3.3 Discuss the specific social, medical and mental health problems faced by asylum seekers placed in detention.
- MCHLC3.4 Institute strategies for effective and culturally appropriate health education and health promotion in local practices.

### 4. Professional and ethical role

- MCHLC4.1 Identify deficiency in knowledge of ethical and legal aspects of consultation with patients from culturally and linguistically diverse backgrounds.
- MCHLC4.2 Identify ways to engage, involve or consult with local culturally and linguistically diverse groups in matters relating to health service delivery to these communities.
- MCHLC4.3 Use and be involved in local culturally and linguistically diverse community health related activities, especially when approached.
- MCHLC4.4 Describe strategies for collaborating with culturally and linguistically diverse communities to eliminate stereotyping and other bias from healthcare.

### 5. Organisational and legal dimensions

- MCHLC5.1 Outline a practice policy for collecting information about the culturally and linguistically diverse backgrounds of patients, including refugees, which attends to the issues of confidentiality and sensitivity.
- MCHLC5.2 Use practice audits or similar activities to assess practice demographics and determine whether the needs of culturally and linguistically diverse groups including refugees are met.

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## *Population health and public health*

### Contents

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Definition	169
Curriculum in practice	170
Rationale and general practice context	171
Training outcomes of the five domains of general practice	172
Learning objectives across the GP professional life	173
<i>Medical student</i>	173
<i>Prevocational doctor</i>	175
<i>Vocational registrar</i>	176
<i>Continuing professional development</i>	178
References	179

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## Definition

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Population health in general practice has been defined as:

*‘The prevention of illness, injury and disability, reduction in the burden of illness and rehabilitation of those with a chronic disease. This recognises the social, cultural and political determinants of health. This is achieved through the organised and systematic responses to improve, protect and restore the health of populations and individuals. This includes both opportunistic and planned interventions in the general practice setting’.*<sup>1</sup>

Population health is the study of health and disease in a population as specified by geographical, cultural or political guidelines.<sup>2</sup> This includes defining health problems and needs, identifying the means by which these needs may be met, and providing the health services required to meet these needs. Other related terms commonly used in general practice include:

- community medicine, which tends to apply more to the integration of population based health interventions in a clinical context
- community health, which is often used to describe the application of broad based public health interventions at a community or individual level.

Public health is the efforts organised by a society to protect, promote and restore people's health.

Population health and public health are the combination of sciences, skills and beliefs directed to the maintenance and improvement of the health of all people through collective or social actions.

There is considerable overlap between population and public health, and differing models of this interface have been developed. A continuum can be considered between population health activities within general practices, public health activities with the community and what have been termed ‘new public health’ movements. These include the engagement of communities, organisational development and specialisation or leadership in fields such as policy development. Some health professionals use the terms population health and public health interchangeably, but there are subtle nuances between these two disciplines.<sup>3-6</sup>

Preventive medicine is the application of preventive measures into medical practice by focusing clinical skills on the health of defined populations in order to promote and maintain health and wellbeing and prevent disease, disability and premature death.

Health promotion is a range of practices including health education, community development, preventive services, policy advocacy and regulations that seek to better health at the individual and population level and goes beyond simple prevention.

In general practice, population health represents an extension and expansion of existing clinical roles toward an emphasis on prevention and a focus on groups or populations, rather than on individual patients. This may involve activities such as immunisation, risk assessment and management, patient education and screening in which general practitioners are already engaged within their practice. General practice public health also involves notification of diseases of public health importance to the relevant government agency.

## Curriculum in practice

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Typical presentations that illustrate how the population health and public health curriculum applies to general practice include:

- Max, 46 years of age, is a school teacher and active member of the local tennis club. His wife has sent him in for a check up. Max says there is nothing wrong, and that he rarely needs to attend the doctor. He does not smoke or drink, has a BMI of 23 has no relevant past or family history and has always been well. What is your management?
- Rhona, 21 years of age, is an Aboriginal woman who has been unwell for some time with vague abdominal aches and episodic diarrhoea. Stool testing had returned negative, possibly due to a delay in transporting the specimen to the pathologist, but her serology shows significant eosinophilia. In reviewing her notes, you discover her eosinophils have been progressively elevated for 3 years and an internet search of the causes of persistent elevation in the Aboriginal population lists strongyloides as a possible cause. Her serology is positive and following treatment her symptoms resolve. What are the implications of this for her and the community? Do you notify the health department?

## Rationale and general practice context

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General practice care goes beyond the individual patient to involve patient populations. General practitioners are ideally placed to implement population based health activities because about 83% of Australians attended a GP at least once during 2009–2010.<sup>7</sup>

### Integrating population health into general practice

A population health approach means implementing these activities more effectively and consistently across a whole population.

Population based health activities in general practice should include, as a priority, activities that are designed to meet the specific needs of at-risk population groups. General practice also has an important advocacy role around the structural issues that affect health status, especially for socially disadvantaged groups.

The best outcomes from general practice population health activities result from:

- better integration across disciplines within primary care
- a partnership between general practice and public health services, and consumer and community organisations.

Population based approaches to prevention and health promotion often require approaches across and beyond the health system.

A useful strategic framework for strengthening and extending general practice involvement in population health at national, state, division and practice levels in Australia includes focus at the following levels<sup>8</sup>:

- organisational structures and roles – developing organisational and practice structures and systems to enable GPs to identify and undertake effective population health activities and interventions, and to facilitate collaboration with outside services and professionals
- communication – including community awareness, patient education and communication between population health and general practice agencies
- information management/information technology – developing population health data collection, dissemination and analysis, and relevant clinical tools and guidelines for information management and decision support
- workforce planning, education and training – developing materials to improve access by general practice staff to education, training and quality assurance programs; and increasing understanding and skills in relation to the population health role of general practice, patient risk assessment and effective interventions
- financial systems – implementing appropriate incentives and payment systems to support the engagement of GPs in effective population health activities both inside and outside the practice
- partnership and referral mechanisms – developing and implementing organisational supports to facilitate effective collaboration between general practice and others working in a population health context
- evaluation and research – participating in research and evaluating alternative models of general practice organisation, funding and integration.

### Related curriculum areas

Refer also to the curriculum statements:

- *Aboriginal and Torres Strait Islander health*
- *Chronic conditions.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- POPT1.1 Enable patients to take control of their health via two-way communication in the form of a patient-doctor partnership.
- POPT1.2 Assess risk factors of individual patients and the broader population.
- POPT1.3 Explain and implement preventive health interventions in general practice, including the modification of lifestyle risk factors.

## 2. Applied professional knowledge and skills

- POPT2.1 Describe the epidemiology of common conditions encountered in Australia and internationally, as well as the recommended preventive activities conducted in the Australian community including general practice.
- POPT2.2 Access current guidelines for screening and prevention.
- POPT2.3 Assess the health needs of specific populations (eg. the elderly, men, women or young people).

## 3. Population health and the context of general practice

- POPT3.1 Describe national health priorities, methods for assessing the health status of a community, and population health and public health approaches to prevention in general practice and the broader community.
- POPT3.2 Know the public health notification requirements for diseases.

## 4. Professional and ethical role

- POPT4.1 Understand professional and ethical obligations to the patient and the broader community, for example, the rights of the individual versus the rights of the community, or patient confidentiality versus the public good.
- POPT4.2 Understand methods of infectious disease control.
- POPT4.3 Liaise and work with other health professionals to optimise population healthcare outcomes and advocate on behalf of patients.

## 5. Organisational and legal dimensions

- POPT5.1 Understand the role of population based general practice activities within the context of the Australian health system, as well as work effectively within these systems to improve the health of patients and the broader community.
- POPT5.2 Understand and incorporate population health activities into general practice management systems.
- POPT5.3 Know the medicolegal duties of the GP in public health.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- POPLM1.1 Take a patient history including risk factors relevant to socioeconomic determinants of health.
- POPLM1.2 Demonstrate the ability to counsel patients about their health risks, especially the risk factors of smoking, nutrition alcohol and physical activity (SNAP).
- POPLM1.3 Outline the use of focused brief advice and other strategies such as cognitive behavioural therapy and motivational interviewing in consultations about the common lifestyle factors of smoking, nutrition alcohol and physical activity.

### 2. Applied professional knowledge and skills

- POPLM2.1 Describe the epidemiology of common conditions in Australia and internationally.
- POPLM2.2 Describe Australian population based health priorities and programs targeting these conditions in Australia.
- POPLM2.3 Compare common causes of Australian mortality to the common causes of Australian morbidity that reduce quality of life.
- POPLM2.4 Describe how socioeconomic determinants of health are related to common illnesses and presentations and be conversant with the evidence supporting this relationship.
- POPLM2.5 Describe the principles of screening and apply these to screening for important diseases in clinical practice.

### 3. Population health and the context of general practice

- POPLM3.1 Describe what health and health outcomes are, how health is measured, national health and public health priorities and their burden of disease.
- POPLM3.2 Discuss the health needs of groups within the Australian population.
- POPLM3.3 Outline preventive programs within Australia including their rationale and evidence for their implementation including in general practice.
- POPLM3.4 Describe the roles of various professional groups, services and programs in prevention of disease and health promotion.
- POPLM3.5 Describe the global burden of disease and the response of the World Health Organization in relation to primary care and general practice.

### 4. Professional and ethical role

- POPLM4.1 Describe principles of confidentiality and notification of communicable diseases to public health authorities.
- POPLM4.2 Describe the ethical issues involved in balancing the individual and public good.
- POPLM4.3 Describe methods for infectious disease control including immunisation, basic hygiene measures (eg. hand washing), quarantine, and control of disease vectors.

## 5. Organisational and legal dimensions

- POPLM5.1 Describe the Australian healthcare system including responsibilities of commonwealth, state and nongovernment organisations and the private sector.
- POPLM5.2 Describe the clinical and population health/public health functions within this system.
- POPLM5.3 Outline how electronic systems can be used to implement and monitor national health priorities within clinical settings.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- POPLP1.1 Demonstrate how to explain to patients how common illnesses and presentations are related to lifestyle factors especially for smoking, nutrition, alcohol and physical activity.
- POPLP1.2 Counsel patients on their need for preventive measures such as Pap tests and immunisations.
- POPLP1.3 Describe the principles of communicating health risks to patients.
- POPLP1.4 Demonstrate discussion of risks with patients.

### 2. Applied professional knowledge and skills

- POPLP2.1 Demonstrate the ability to counsel women about cervical smears and chlamydia screening, perform a Pap test and explain any results (see *Women's health* curriculum statement).
- POPLP2.2 Describe common infectious diseases in Australia, including their diagnosis, treatment and management (including immunisation and other forms of prevention).

### 3. Population health and the context of general practice

- POPLP3.1 Describe the roles of different parts of the health system in conducting screening and surveillance for diseases in the hospital and community context.
- POPLP3.2 Explain the role of GPs in working with hospital based services to reduce the burden of diseases within a community.

### 4. Professional and ethical role

- POPLP4.1 Demonstrate a nonjudgmental approach to patients and their lifestyle choices.
- POPLP4.2 Counsel patients about the need for testing for infectious diseases, including the need for disease notification if a test is positive.

### 5. Organisational and legal dimensions

- POPLP5.1 Discuss principles of patient information and recall systems, screening and measures and program to improve patient safety in clinical care including electronic systems.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge — prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- POPLV1.1 Give focused brief advice and consider the appropriateness of other strategies such as cognitive behavioural therapy and motivational interviewing in consultations about the common lifestyle factors of smoking, nutrition, alcohol and physical activity.
- POPLV1.2 Explain to patients that lifestyle factors may cause many common illnesses and modification of these risk factors needs to be part of a management plan.
- POPLV1.3 Counsel patients about recommended screening tests including tests that are not universally recommended, but which patients may request (eg. prostatic specific antigen or chest X-ray).
- POPLV1.4 Describe methods for liaising with other health professionals within the healthcare system to optimise healthcare and advocate on behalf of the patient.
- POPLV1.5 Describe strategies for implementing a public health approach in the general practice setting.

### 2. Applied professional knowledge and skills

- POPLV2.1 Describe preventive guidelines in Australian general practice and the rationale and evidence for their development.
- POPLV2.2 Undertake a needs assessment in a community to identify health priorities. This could include capacity to interpret printed information and papers, interpreting health data and skills in liaising with key stakeholders in the community.
- POPLV2.3 Apply principles of epidemiology and biostatistics sufficient to critically interpret papers.
- POPLV2.4 Describe the epidemiology of illness in special populations including rural areas of Australia.
- POPLV2.5 Describe the impact of rural and remote practice on equity and access to health services.

### 3. Population health and the context of general practice

- POPLV3.1 Describe the roles of different parts of the health system in conducting screening and surveillance for diseases in the general practice context.
- POPLV3.2 Develop recall systems and other measures in the general practice setting to implement preventive guidelines including electronic systems.
- POPLV3.3 Audit performance of self and practice in relation to population health activities, especially immunisation, screening and management of lifestyle risk factors.
- POPLV3.4 Conduct an assessment of the health needs within the general practice and the local community.
- POPLV3.5 Discuss the advantages and disadvantages of preventive practices and individualise

this advice to the patient's needs.

- POPLV3.6 Work with a multidisciplinary team to implement preventive strategies in a practice or community.
- POPLV3.7 Identify occupational health factors that may influence disease.
- POPLV3.8 Demonstrate infection control measures within the general practice setting consistent with the RACGP *Infection control standards for office based practices*.

#### 4. Professional and ethical role

- POPLV4.1 Differentiate between clinical and public health roles to the broader community (disease notification, involvement in surveillance networks) in general practice.
- POPLV4.2 Describe specific public health issues relevant to rural practice and other close communities, such as confidentiality and the fact small populations may be identified in research undertaken by the GP.
- POPLV4.3 Manage patients found to have an infectious diseases, including notification requirements.

#### 5. Organisational and legal dimensions

- POPLV5.1 Be conversant with aspects of public health legislation relevant to general practice.
- POPLV5.2 Implement population approaches in your general practice work.
- POPLV5.3 Discuss the advantages and disadvantages of implementing population health approaches into general practice activities.
- POPLV5.4 Develop strategies to overcome barriers to the implementation of population health approaches in general practice, as outlined in the RACGP publication *Putting prevention into practice* (the green book).
- POPLV5.5 Evaluate recall systems to ensure at risk patients receive necessary follow up.
- POPLV5.6 Describe the role of the GP as part of a larger healthcare system.
- POPLV5.7 Explain the role of health informatics in improving the general practice contribution to population health.
- POPLV5.8 Develop skills in evaluation (clinical audit) to assess the process indicators, and the impact and outcomes of population health strategies implemented in practice.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational GP

### 1. Communication skills and the patient-doctor relationship

- POPLC1.1 Describe and explain to patients current and emerging public health problems (eg. SARS, pandemic influenza) and the appropriate response.

### 2. Applied professional knowledge and skills

- POPLC2.1 Describe successful strategies to encourage disadvantaged groups to present to general practice for preventive care.
- POPLC2.2 Develop evaluation and research method skills.

### 3. Population health and the context of general practice

- POPLC3.1 Maintain a practice register and extract information from it.
- POPLC3.2 Implement prevention and health promotion among particular population groups including people from culturally and linguistically diverse backgrounds, refugees and Aboriginal and Torres Strait Islander people.
- POPLC3.3 Describe strategies for mental health promotion in general practice among particular population groups.
- POPLC3.4 Describe and implement strategies in general practice for injury and violence prevention.

### 4. Professional and ethical role

- POPLC4.1 Demonstrate ability to access latest relevant population health data, including the use of information technology.
- POPLC4.2 Demonstrate that general practice standards and professional development of population health are regularly reviewed.
- POPLC4.3 Describe the ethics of resource allocation in healthcare, for example, different geographical areas and the role of the medical profession in advocacy for individual patients and population groups.
- POPLC4.4 Demonstrate the ability to work as a part of a team, both within the practice and with health professionals outside the practice to promote health and reduce health inequalities.
- POPLC4.5 Consider, where appropriate, further studies in public health such as a Masters of Public Health, faculty of public health medicine training, or other opportunities for public health training applicable to GPs.

### 5. Organisational and legal dimensions

- POPLC5.1 Demonstrate implementation of legislative changes affecting population based health.
- POPLC5.2 Regularly review practice systems in place, including electronic process for recall systems to ensure patients at risk receive necessary follow up.
- POPLC5.3 Outline practice infection control processes consistent with the RACGP *Infection control standards for office based practices*.

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## *Rural general practice*

### Contents

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Definition	183
Curriculum in practice	183
Rationale and general practice context	184
Training outcomes of the five domains of general practice	186
Learning objectives across the GP professional life	190
<i>Medical student</i>	190
<i>Prevocational doctor</i>	191
<i>Vocational registrar</i>	192
<i>Continuing professional development</i>	194
References	196

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## Definition

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In addition to general practice as defined by The Royal Australian College of General Practitioners (RACGP)<sup>1</sup>, rural general practice provides its own diversity of contexts and characteristics of general practice.<sup>2</sup>

In rural and remote Australia, geographical and demographic features lead to great diversity in both the range of presentations general practitioners may encounter and the facilities that may be available to administer primary care.<sup>2</sup>

Rural GPs are more likely to: provide in-hospital care as well as private consulting room care, provide after hours services, engage in public health roles expected of them by discrete communities in which there are few doctors to choose from, engage in clinical procedures, engage in emergency care, encounter a higher burden of complex or chronic health presentations, and encounter larger proportions of Aboriginal or Torres Strait Islander patients in their overall patient load.<sup>2-5</sup>

The extent to which the GP will engage in any of these activities and roles, however, will depend on the rural or remote practice context and the range of general practice skills in which they are required. For example, some rural doctors in smaller rural towns are based primarily at the local hospital, but the practice they conduct is still predominantly primary medical care, even though some secondary and tertiary care is also possible due to the hospital facilities.<sup>2</sup>

Rural GPs often value:

- professional autonomy<sup>3</sup>
- the range of medicine practised
- practising to the extent of their clinical knowledge and skills
- value the communities in which they work
- being valued by the community.<sup>6</sup>

In addition, rural GPs are more likely to experience professional and social isolation than their peers in urban contexts.

While rural practice requirements conform to the core curriculum set for the Fellowship of the RACGP (FRACGP), they will also involve specific skill sets appropriate to the rural and/or remote health context. These skill sets may be practised at an extended or advanced level, depending on patient requirements. These characteristics and practices are supported by the RACGP *Standards for general practices* and a curriculum developed and maintained by the RACGP and reflected in the award of Fellowship of Advanced Rural General Practice (FARGP).

## Curriculum in practice

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The following case illustrates how the rural general practice curriculum applies to general practice:

- Emily, 23 years of age, has returned to your small country town following the breech birth of her fourth child, Ben. The baby has been identified with talipes equinovarus, which is twice as common in the children of smokers (like Emily). She has been told she needs to return for weekly assessment and treatment in the city, taking 2 days of travel each time. She tearfully asks if there is any way this can be avoided. The crop is about to be harvested and she will be desperately needed at home to run the financial part of the family business, as well as care for the other children. She also cooks for the contracted workers. The family simply cannot afford to have her absent, nor does she have anyone to stay with in the regional centre to help reduce the costs of travel and accommodation.

## Rationale and general practice context

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Australia is predominantly an urban society. In June 2010, of the estimated 21 951 736 people living in Australia, 68.7% of the population was living in major cities, 19.7% in inner regional Australia, 9.3% in outer regional Australia, 1.4% in remote Australia and 0.8% in very remote Australia.<sup>7</sup> The supply of GPs per patient population is significantly lower in remote areas than in major areas, as is access to medical specialists.<sup>8</sup> Geographical isolation and social accessibility are significant factors in the decision to attend a GP for rural patients.<sup>9</sup>

Health outcomes, such as death rates, tend to be poorer outside major cities.<sup>10</sup> The main contributors to higher death rates in regional and remote areas are coronary heart disease and other circulatory diseases, chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, other injuries and some cancers such as lung cancer – perhaps reflecting differences in access to services, risk factors and the regional/remote environment.

Rural areas have lower rates of some hospital surgical procedures, lower rates of general practice consultation and there are generally higher rates of hospital admission in regional and remote areas than in major cities.<sup>11</sup> People from regional and remote areas tend to be more likely to smoke and drink alcohol in harmful or hazardous quantities than people in major cities.<sup>12</sup> Environmental issues such as more physically dangerous occupations and factors associated with hazardous driving play a part in higher accident rates and related injury/death in country areas.<sup>12</sup>

Higher death rates and poorer health outcomes outside major cities, especially in remote areas, also reflect the higher proportions of the populations in those areas who are Aboriginal or Torres Strait Islander.<sup>13,14</sup>

Because rural communities in general have higher levels of morbidity and mortality, the rural GP has an important and evolving role, with the potential to influence change at the individual patient, practice and community levels within the healthcare system. Rural GPs are more likely to be key players in local hospitals and also be called upon by local authorities to play a public health role, such as a police medical officer. To optimise their effectiveness in providing primary healthcare to their communities, the rural GP needs to develop a detailed understanding of the particular sociopolitical, economic, geographical, cultural and family influences on the health of their patients.

### Rural general practice training in addition to the FRACGP

All medical practitioners require an understanding of what may be helpful for working in rural and remote environments such as procedural skills and knowledge of Aboriginal health, hospital work and population health. A knowledge of rural health is an essential part of preparing a general practitioner for unsupervised practice anywhere in Australia. This curriculum will assist any general practitioner to understand the knowledge, skills and competencies helpful for unsupervised practice anywhere in rural Australia.

Doctors with a particular interest in rural general practice can integrate enhanced rural training with general practice vocational training toward the FRACGP under the formal framework offered by the RACGP FARGP.

These doctors may also wish to undertake advanced rural skills (ARS) training in curriculum shared with other medical specialties such as anaesthesia, obstetrics, emergency medicine and mental health. These have additional curriculum requirements to those of the FRACGP. Specific curriculum statements have been developed by joint consultative committees between the RACGP and relevant specialist colleges.

These advanced rural skills are not required for attainment of the FRACGP, or included in this rural general practice curriculum statement. However, 12 months of training in accredited ARS posts is required for attainment of the FARGP. Doctors planning to undertake ARS training are encouraged to integrate these into their general practice vocational training, under the FARGP framework. Medical students, postgraduate doctors and general practice registrars are encouraged to undertake as much of their education and training in rural general practice as practicable.

Most RACGP curriculum statements will refer to rural and remote contexts. This rural curriculum statement serves both as the rural statement of the RACGP curriculum in general and as the baseline curriculum for the RACGP FARGP.

As a qualification beyond vocational FRACGP, FARGP candidates, for which the full 12 months of ARS training is undertaken in the one ARS curriculum, can include that curriculum in their postnominals, ie. a 12 months ARS training post in obstetrics, the postnominal is FARGP (Obst). This assists the graduate in seeking visiting medical officer credentialing in rural hospitals.

Please check the FARGP information available on the National Rural Faculty page of the RACGP website for specific educational and assessment requirements of the FARGP.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- RURT1.1 Understand that effective communication skills of the rural general practitioner need to take into account the likelihood of higher than average workloads and the greater reluctance of many patients to freely discuss problems they may experience.
- RURT1.2 Recognise that in a local rural environment, where patients are friends and neighbours, special care is required to communicate with patients in a manner not likely to confuse professional, social and personal boundaries.
- RURT1.3 Establish rapport and be empathetic with patients from different socioeconomic, occupational and cultural background within rural communities.
- RURT1.4 Adopt verbal and nonverbal communication styles appropriate to the diverse needs of patients in rural communities.
- RURT1.5 Incorporate a particular communication emphasis on health promotion and education to increase patients' willingness to look after themselves, especially in relation to major risk factors in rural communities.
- RURT1.6 Communicate to patients appropriate doctor-patient boundaries associated with living within a close knit rural community.
- RURT1.7 Develop a specific cultural awareness of the indigenous populations living within the boundaries of the medical practice.
- RURT1.8 Manage communication sensitively on issues such as family arrangements during transfer to a major centre for treatment.
- RURT1.9 Appreciate the different cultural norms of interpersonal communication for specific patient populations (eg. Aboriginal and Torres Strait Islander people, non-English speaking people), and acquire knowledge to be able to communicate effectively with these patient groups.

## 2. Applied professional knowledge and skills

- RURT2.1 Recognise that rural GPs are likely to be called upon to manage a wider range of patient presentations including emergency treatment, obstetrics and minor and major procedures without referral.
- RURT2.2 Recognise that rural communities place great reliance on the applied professional skills of their resident GPs whose response must be skilful and appropriate in order to instil confidence and trust.
- RURT2.3 Recognise and manage the range of common and significant patient presentations found in rural communities.
- RURT2.4 Demonstrate a comprehensive knowledge of relevant anatomy, physiology, pathology and psychology including related research findings in the management of conditions commonly found in rural practice.
- RURT2.5 Competently manage the range of illness and disease occurring in their community, including possible serious illness, which may be inherent in many common presentations.
- RURT2.6 Demonstrate enhanced clinical skills in the management of common conditions according to the communities needs.
- RURT2.7 Demonstrate continual improvement in the repertoire of procedural and clinical skills required for effective general practice in their rural communities, and the ability to perform appropriate medical procedures under minimal, or no supervision according to the community needs.

- RURT2.7 Demonstrate the ability to manage emergencies to the level of skill attained in recognised intensive emergency medicine courses such as the early management of severe trauma, advanced paediatric life support, advanced life support obstetrics, clinical emergency management program and emergency life support including the management of emergencies in the rural hospital setting.
- RURT2.8 Demonstrate a level of competence in those aspects of medicine, surgery, paediatrics, obstetrics, intensive care and anaesthesia appropriate to the practice of a rural GP taking part in in-patient/hospital care.
- RURT2.9 Demonstrate ability to take X-rays and use teleradiology facilities and ultrasound when necessary.
- RURT2.10 Demonstrate competent implementation of procedures for evacuation, disaster, trauma management and retrieval.
- RURT2.11 Recognise and take into account the factors that need to be balanced when arranging an evacuation, including family considerations.
- RURT2.12 Implement appropriate protocols for arranging an evacuation and for undertaking the preparations required in a community for air evacuations.
- RURT2.13 Demonstrate competent performance of appropriate diagnostic procedures relevant to the advanced skills of rural general practice.
- RURT2.14 Make decisions with confidence and accept the outcomes of these decisions while working within their limitations.

### 3. Population health and the context of general practice

- RURT3.1 Provide or contribute to ongoing health education and health promotion sessions for other rural health professionals and members of their rural community.
- RURT3.2 Develop a detailed working knowledge of their rural community's patterns of morbidity and mortality, health services, and be able to participate in regional and national community based prevention and education strategies.
- RURT3.3 Apply public health principles including disease control management and utilise the appropriate health and community service networks as part of their rural practice.
- RURT3.4 Participate in a range of public health roles as appropriate.
- RURT3.5 Understand the need for multidisciplinary teamwork with other healthcare practitioners and crosssectoral nonhealth organisations in rural areas.
- RURT3.6 Deliver an appropriate level of care with an understanding of the limitations of resources in rural general practice.
- RURT3.7 Involve consumer groups in the development of policies relating to health service provision
- RURT3.8 Utilise relevant protocols and guidelines and, where necessary, participate in development of these guidelines, both for acute and preventive care.
- RURT3.9 Demonstrate an understanding of the environmental, social and cultural influences on illness, health needs and priorities of rural and remote people and their communities.
- RURT3.10 Recognise the importance of the family unit and the home environment, in illness and health, and acknowledge the extended support structures.
- RURT3.11 Utilise the extended role of other healthcare practitioners in rural areas, recognising the value of multidisciplinary teamwork.

## 4. Professional and ethical role

- RURT4.1 Understand the duty of care and medicolegal issues of the rural GP, who may deal with more emergency cases and procedural medicine than urban based GPs.
- RURT4.2 Understand the potential ethical dilemmas arising from the multiple roles that GPs fulfil in small communities.
- RURT4.3 Improve skills in critical self reflection and evaluation of their practice to ensure that the needs of the rural communities they serve are met as effectively as possible.
- RURT4.4 Develop skills in balancing the case load and demands of working in isolation in a rural practice with the associated social and personal responsibilities, self care and self reliance, family, and potential difficulties associated with professional and social boundaries in a small rural community.
- RURT4.5 Establish professional networks and utilise available rural resources and referral agencies.
- RURT4.6 Understand the difficulties and importance of maintaining confidentiality in small communities.
- RURT4.7 Be skilled in providing mentoring support for peers and others in the rural GP learning life cycle.
- RURT4.8 Know the procedures and level of response required for local emergency and disaster situations.

## 5. Organisational and legal dimensions

- RURT1.1 Be able to work effectively as part of a multidisciplinary team.
- RURT1.2 Articulate and maintain good working relationship with all members of hospital staff/ hierarchy.
- RURT1.3 Balance time management between the demands of the consulting rooms and the community hospital as required.
- RURT1.4 Demonstrate awareness of local issues that affect the GP's decision to treat the patient locally, or to refer onto other services, which may be distant from the practice area.
- RURT1.5 Develop an understanding of the principles of small business management relevant to a rural general practice.
- RURT1.6 Apply the principles of triage and disaster management in the rural setting.
- RURT1.7 Apply appropriate protocols for hospital, home and hostel visiting.
- RURT1.8 Understand the principles of public health, including disease control arrangements within their state and utilise appropriately public health infrastructure.
- RURT1.9 Know the legal responsibilities regarding notification of disease, birth, death, autopsy, nonaccidental injury and substance abuse.
- RURT1.10 Appropriately prioritise patient management in rural general practice, according to individual patient needs, time and other resources available.
- RURT1.11 Recognise stress and grief symptoms in staff, patients, their relatives and friends, and provide empathic and culturally appropriate support and follow up.
- RURT1.12 Be able to obtain informed patient consent during medical procedures in the rural setting and in emergency care.

- RURT1.13 Be able to apply transfer and evacuation procedures from the rural community.
- RURT1.14 Apply the principles of retrieval medicine.
- RURT1.15 Establish and utilise a comprehensive professional emergency referral network.
- RURT1.16 Be able to apply the jurisdictional legislation relevant to involuntary admission to a psychiatric unit, power of attorney, child protection and abuse and guardianship.
- RURT1.17 Be able to access the metropolitan clinical, academic, research, literature, hotline and legal resources available.
- RURT1.18 Keep comprehensive patient records and be able to articulate why this is important.
- RURT1.19 Be aware of local issues that influence the GP's decision to treat a patient locally, or refer onto more distance health faculties.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- RURLM1.1** Demonstrate how to establish rapport and empathy with patients from different socioeconomic, occupational and cultural background within rural communities.

### 2. Applied professional knowledge and skills

- RURLM2.1** Demonstrate the ability to recognise the range of common and significant patient presentations found in rural communities.
- RURLM2.2** Outline the basic management of the range of illness and disease occurring in their rural communities including possible serious illness, which may be inherent in many common presentations.
- RURLM2.3** Identify cross-cultural issues applying to rural general practice including Aboriginal and Torres Strait Islander health in rural and remote communities.

### 3. Population health and the context of general practice

- RURLM3.1** Outline how the socioeconomic, environmental and social factors of rural and remote areas contribute to poorer health outcomes, including those of Aboriginal and Torres Strait Islander people.
- RURLM3.2** Outline differences in basic public health issues relevant to rural communities such as access to clean water, adequate housing and sanitation.
- RURLM3.3** Outline the structures and processes in place to address pandemic or epidemic disease, prevent general morbidities and preserve health and wellbeing in rural Australia.

### 4. Professional and ethical role

- RURLM4.1** Describe the professional challenges and rewards of rural general practice and the role of the GP in addressing the rural health inequities.
- RURLM4.2** Describe the professional role of a GP in a rural community, including community trust, and the responsibility to practice medicine safely, with due care and strictly within guidelines of professional conduct.
- RURLM4.3** Outline ethical questions that arise specifically in rural practice and formulate potential responses.
- RURLM4.4** Describe the ethical issues associated with maintaining patient confidentiality in the range of general practice contexts found in rural Australia.

### 5. Organisational and legal dimensions

- RURLM5.1** Describe local issues that influence the GP's decision to treat the patient locally or to refer to other services.
- RURLM5.2** Outline the principles of triage or disaster management in the rural setting.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- RURLP1.1 Demonstrate use of appropriate verbal and nonverbal skills for a rural setting.
- RURLP1.2 Demonstrate how to communicate to patients the restrictions of appropriate doctor-patient boundaries associated with living within a close knit rural community.

### 2. Applied professional knowledge and skills

- RURLP2.1 Demonstrate development in the competent management of the range of common and significant patient presentations in the rural setting.
- RURLP2.2 Demonstrate improvement in procedural and clinical skills required for effective general practice in their rural communities, including those skills required for the management of emergencies.

### 3. Population health and the context of general practice

- RURLP3.1 Demonstrate application of public and population health principles (see also curriculum statement on Population health and public health) in a rural setting.
- RURLP3.2 Observe and outline the relationship between socioeconomic disadvantage and poor health in rural communities, ideally through clinical experience in a range of rural health facilities.

### 4. Professional and ethical role

- RURLP4.1 Describe the role of the rural GP in their community, including both primary and secondary, and sometimes tertiary secondary care.
- RURLP4.2 Document exposure to, and work within, a rural environment to the professional limit of the skills acquired and supervision necessary.
- RURLP4.3 Describe the ethical questions that arise in rural practice and potential responses.
- RURLP4.4 Outline how best to balance the potential conflicts in a professional role and the ethical concerns arising both from the complexity of rural practice and patients, and from the multiple roles that GPs fill in small communities.
- RURLP4.5 Demonstrate preliminary steps taken in ensuring a balance of work, self care and family both at present and for a future medical career.

### 5. Organisational and legal dimensions

- RURLP5.1 Outline time management strategies to balance the competing demands of consulting rooms and community hospital commitments in rural practice.
- RURLP5.2 Identify local issues that influence your general practice's decision to treat a patient locally or to refer on.
- RURLP5.3 Articulate the operational principles of triage and disaster management relevant to rural general practice.
- RURLP5.4 Appropriately prioritise patient needs, time and other resources available.
- RURLP5.5 Demonstrate knowledge of patient consent procedures.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- RURLV1.1 Demonstrate the adaptation of appropriate verbal and nonverbal communication styles to the needs of patients in rural communities.
- RURLV1.2 Demonstrate a capacity to use health promotion and education to increase patient willingness to look after themselves, especially in relation to major risk factors in rural communities.
- RURLV1.3 Show how to communicate to patients appropriate doctor-patient boundaries, associated with living within a close-knit rural community.
- RURLV1.4 Demonstrate multicultural awareness of people from culturally and linguistically diverse backgrounds living within the patient catchment of the medical practice.
- RURLV1.5 Demonstrate specific cultural awareness of the indigenous populations living within the patient catchment of the medical practice.

### 2. Applied professional knowledge and skills

- RURLV2.1 Demonstrate the competent management of the range of common and significant patient presentations in the rural setting.
- RURLV2.2 Demonstrate further improvement in procedural and clinical skills required for effective general practice in their rural communities, including those skills required for the management of emergencies.
- RURLV2.3 Competently implement procedures for evacuation, disaster, trauma management and retrieval.

### 3. Population health and the context of general practice

- RURLV3.1 Demonstrate participation in ongoing health education and health promotion in rural communities.
- RURLV3.2 Describe local rural community patterns of morbidity and mortality, the health services available to address these and any improvement in services required.
- RURLV3.3 Apply public health principles to disease control management in the practice and hospital setting.
- RURLV3.4 Utilise the appropriate health and community service networks as part of rural practice.
- RURLV3.5 Demonstrate an informed commitment to primary healthcare delivery through inter-professional cooperation.

## 4. Professional and ethical role

- RURLV4.1 Demonstrate appropriate care, responsibility and respect for patient rights and a preparedness to act as advocate for patients.
- RURLV4.2 Outline the difficulties and importance of maintaining confidentiality in small communities.
- RURLV4.3 Describe the difficulties and potential ethical dilemmas arising from the multiple roles that GPs fill in small or rural communities.
- RURLV4.4 Outline the avenues with which ethical concerns or professional conflict can be discussed and resolved, including referral agencies.
- RURLV4.5 Demonstrate steps required to ensure a balance between work, self care and family, both during registrar training in the rural setting and beyond vocational fellowship.

## 5. Organisational and legal dimensions

- RURLV5.1 Demonstrate an understanding of the principles of practice/small business management relevant to rural general practice.
- RURLV5.2 Implement the principles of triage and disaster management in the rural setting.
- RURLV5.3 Outline legal responsibilities regarding notification of disease, births, deaths, autopsy, non-accidental injury and substance use in the rural setting.
- RURLV5.4 Establish and utilise comprehensive professional referral network appropriate to the rural setting.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- RURLC1.1 Demonstrate a specific cultural awareness of the indigenous populations living within the boundaries of the medical practice in the rural setting.
- RURLC1.2 Demonstrate improvement in the ability to manage communication with sensitivity when sensitive issues are involved in a rural setting, for example, family issues when a patient is transferred to a major centre.
- RURLC1.3 Engage in periodic review or audit of communication skills.

### 2. Applied professional knowledge and skills

- RURLC2.1 Demonstrate engagement with continuing improvement activities in all curricular areas including procedural and emergency skills.
- RURLC2.2 Demonstrate ongoing competence in diagnostic and clinical skills appropriate to the rural setting including in telemedicine.

### 3. Population health and the context of general practice

- RURLC3.1 Demonstrate the capacity to place special emphasis on health promotion and education to increase patients' willingness to look after themselves, especially in relation to major risk factors in rural communities.
- RURLC3.2 Review the changing approaches to public health issues including changing causes of morbidity and mortality in the rural setting.

### 4. Professional and ethical role

- RURLC4.1 Demonstrate critical assessment of the sources of learning and application of new managements/treatments/technologies with competence in the rural context where appropriate.
- RURLC4.2 Provide a professional example to medical students, interns and registrars of the highest possible standard, especially in relation to respecting patient rights, advocacy and confidentiality within the community.
- RURLC4.3 Facilitate exposure of professional and ethical dilemmas to medical students, junior doctors and registrars in a teaching environment.
- RURLC4.4 Demonstrate ongoing critical self reflection and evaluation of rural general practice to ensure the needs of the rural communities are met as effectively as possible.
- RURLC4.5 Demonstrate the ability to effectively use and maintain professional networks and utilise available rural resources and referral agencies in a context of continuous improvement.
- RURLC4.6 Demonstrate a commitment to continuing self directed learning and professional development in rural practice sufficient to improve the quality of medical care provided.
- RURLC4.7 Demonstrate ongoing improvement in balancing the demands of working in isolation in a rural practice with social and personal responsibilities, self care and family.

## 5. Organisational and legal dimensions

- RURLC5.1 Demonstrate the delivery of appropriate level of care and prioritise patient management in rural general practice according to individual needs, time and the limits of resource in rural general practice.
- RURLC5.2 Assist medical students, interns and registrars in understanding the role of the GP in the community hospital and in other public health roles found in rural contexts.
- RURLC5.3 Demonstrate improving competence in the delivery of a combination of primary and secondary care.
- RURLC5.4 Assist medical students, interns and registrars in understanding the local issues that affect the GP's decisions to treat the patient locally or to refer on.
- RURLC5.5 Modify practice business models to maximise practice sustainability within the workforce constraints and higher and more complex patient demands of rural primary healthcare.

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## *Women's health*

### Contents

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Definition	199
Curriculum in practice	199
Rationale and general practice context	200
Training outcomes of the five domains of general practice	202
Learning objectives across the GP professional life	204
<i>Medical student</i>	204
<i>Prevocational doctor</i>	206
<i>Vocational registrar</i>	207
<i>Continuing professional development</i>	208
References	209

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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## Definition

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The general practice management of women's health involves a holistic patient centred approach to the physical, mental and emotional health of women, their families, and their relationships.<sup>1</sup> Women's health needs to be understood in the context of their psychosocial and cultural environment.<sup>2,3</sup>

## Curriculum in practice

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Typical presentations that illustrate how the women's health curriculum applies to general practice include:

- Michelle's mother is at her wit's end. Every month her 14 year old daughter becomes moody and aggressive, just prior to her menses, to such a degree that she has taken to keeping her home from school to avoid the otherwise inevitable detentions. She wants to know, 'Should Michelle start the pill?'
- Annalise is nearing 50 years of age and her periods have become irregular and very heavy. A regular blood donor, she was recently refused because her count was too low. Her serology confirms that her haemoglobin is 97 g/L with a picture of iron deficiency. What investigations are appropriate and which treatment options might be considered?
- Kylie, 31 years of age, has always been a large girl but lately you notice she has also become hirsute and you are able to confirm polycystic ovarian syndrome. Which treatments are most effective in preserving fertility? What other diseases is Kylie at risk of developing?

## Rationale and general practice context

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As 57% of Australian general practice consultations are with women,<sup>4</sup> the gender specific primary health needs of women constitute a significant proportion of the general practice workload.

Women tend to make most healthcare decisions for their family, tend to request more information than men, expect a greater role in decision making, and often have higher expectations of timeliness and quality of healthcare provision.<sup>5</sup>

Barriers to accessing general practice may include:

- general access and equity issues such as financial restrictions, lack of available child care, lack of access to transport
- cultural issues impacting on access to healthcare related to a lack of availability of the appropriate gender or culture of primary health provider and language barriers
- fear of discrimination and disclosure of sensitive issues for a wide range of marginalised and vulnerable groups, including Aboriginal and Torres Strait Islander women; immigrant women; same-sex attracted women; and disabled, abused, homeless and refugee women.

Gender specific health issues in general practice care across a woman's lifespan often involves accessing multiple healthcare providers, including those in relation to reproductive issues. Regular preventive healthcare is also a large part of women's health.<sup>6</sup>

Specific health problems can be related to gender power differences such as lower income than men or being subjected to violence.

The key principles for delivering quality women's healthcare in general practice include:<sup>7,8</sup>

- understanding key gender differences in health and illness
- responding to the particular health needs of women associated with their social roles, responsibilities and position, and reproductive health needs
- understanding the need for women to have access to sensitive healthcare and choices in healthcare providers
- being aware of common differences in practice styles of female general practitioners, including a tendency to provide longer consultations, more preventive health and mental health/counselling
- understanding the strengths, weaknesses and limitations of general practice in meeting women's health needs, including issues of equity and access to health information and services for women.

## National Women's Health Policy 2010

The aims of the women's health curriculum statement are consistent with and support the National Women's Health Policy 2010,<sup>3</sup> which outlines five key goals that aim to improve the health and wellbeing of all women in Australia by facilitating women's access to healthcare services and information, and to encourage the health system and government to be more responsive to the health needs of women.

The National Women's Health Policy 2010 identifies that marginalisation and discrimination can affect access to healthcare resources and states that 'those who are discriminated against, or who cannot find culturally appropriate services, may withdraw from seeking help altogether'.<sup>3</sup> Specific marginalised groups of women highlighted as requiring particular attention for healthcare include Aboriginal and Torres Strait Islander women; migrant and refugee women; and disabled, lesbian and bisexual women.

The policy goals highlight ways that gender inequality and health inequities can be addressed through:

- highlighting the significance of gender as a key determinant of women's health and wellbeing
- acknowledging that women's health needs differ according to their life stage
- prioritising the needs of women with the highest risk of poor health
- ensuring that the health system is responsive to all women, with a clear focus on illness and disease prevention and health promotion
- supporting effective and collaborative research, data collection, monitoring, evaluation and knowledge transfer to advance the evidence base on women's health.

## Related curriculum areas

Refer also to the curriculum statement:

- *Sexual health.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- WOMT1.1 Understand how gender, power and cultural differences can influence the dynamics of the patient-doctor relationship and consequent effective communication.
- WOMT1.2 Acknowledge how the doctor's gender may also impact on the disclosure of sensitive issues.
- WOMT1.3 Be sensitive to history and examination processes and respect patient autonomy to facilitate good patient care, for example obtaining consent for physical examination including adequate explanation of its purpose, the use of screens and drapes and the role of chaperones.

## 2. Applied professional knowledge and skills

- WOMT2.1 Manage a wide range of gender specific health conditions.
- WOMT2.2 Understand the evidence based knowledge of the physical, psychological, social and cultural factors impacting on these conditions to facilitate quality women's general practice healthcare. For example, understand the impact of hormonal fluctuations on women's physical and mental health including menarche, menopause, premenstrual syndrome, pregnancy, breastfeeding and postnatal changes, and that these occur within a framework of diverse cultural, social, economic, psychological and emotional needs.

## 3. Population health and the context of general practice

- WOMT3.1 Understand how the roles and position of women in Australian society are critical to delivering quality primary care.
- WOMT3.2 Understand how quality care involves recognising that certain cultural groups will need to see only female doctors.
- WOMT3.3 Recognise that there are differing health beliefs and health seeking behaviours of women from different cultures.
- WOMT3.4 Address the health inequalities of socially disadvantaged groups of women including Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds (including those with language barriers), disabled women, women with mental health problems, women living in rural and remote areas, lesbian and bisexual women, single mothers, women with drug and alcohol problems, homeless women, refugees and asylum seekers, women in prison, chronically unemployed women, and women who have experienced abuse at any stage of their life.
- WOMT3.5 Incorporate gender sensitive strategies for women into general practice health promotion and public health prevention programs, while also recognising the diverse backgrounds of women.
- WOMT3.6 Work in conjunction with the other women's health groups to effectively deliver quality care to women such as women's health centres, BreastScreen Australia, as well as community based organisations.

## 4. Professional and ethical role

- WOMT4.1      Respect women's autonomy in their healthcare and decision making. The clinician needs to be aware of their own values and the potential impact of these values on management decisions, especially in sensitive issues such as reproductive medicine.
- WOMT4.2      Understand how effective management of the practical considerations of consent and confidentiality is facilitated by a gender sensitive trusting patient-doctor relationship.
- WOMT4.3      Acknowledge and implement ethical considerations, including referring to female doctors on request, the use of chaperones when appropriate, reproductive ethics and the role of the GP as patient advocate.

## 5. Organisational and legal dimensions

- WOMT5.1      Ensure attention to patient confidentiality and the recording of sensitive medical information to protect women's health, especially when in vulnerable situations such as intimate partner violence.
- WOMT5.2      Know the treating doctor's legal obligations (eg. notification of child abuse, sexually transmissible infections) and how antidiscrimination laws impact on their role in caring for women.
- WOMT5.3      Know age of consent confidentiality issues for young people wanting contraception or referral for termination of a pregnancy.
- WOMT5.4      Know the legal issues relating to abortion, access to assisted reproductive technology, adoption, age of consent, and end-of-life decision making in Australia (as the laws may vary in each state or territory).

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- WOMLM1.1 Apply principles of women centred clinical care, including encouraging an equal partnership, shared decision making and recognising the role of gender and power in the patient-doctor relationship.
- WOMLM1.2 Outline cultural issues in communication pertaining to gender including:
  - WOMLM1.2.1 understanding Australian society and the healthcare needs of women
  - WOMLM1.2.2 being aware that some cultural groups prefer to see doctors of a particular gender or cultural background
  - WOMLM1.2.3 acknowledging the health beliefs and health seeking behaviours of women from different cultures
  - WOMLM1.2.4 understanding the influence of the doctor's gender on disclosure of sensitive issues.
- WOMLM1.3 Demonstrate facilitation of communication with women attending with dependants such as children, disabled/elderly family or friends.
- WOMLM1.4 Demonstrate sensitive and empathic facilitation of disclosure with regard to intimate issues including sexual health, sexual orientation, gender identity, body image and all forms of abuse.

### 2. Applied professional knowledge and skills

- WOMLM2.1 Demonstrate skills in physical examination, in medically justified circumstances, that creates a sense of comfort and safety for the patient.
- WOMLM2.2 Demonstrate the ability to perform intimate examinations under supervision with sensitivity and care, allowing the woman to control the process, including:
  - WOMLM2.2.1 cervical screening
  - WOMLM2.2.2 pelvic examination
  - WOMLM2.2.3 breast examination.
- WOMLM2.3 Discuss the effect of biological factors on women's health.
- WOMLM2.4 Demonstrate knowledge of women's health issues, problems, conditions and diseases, including those associated with fertility and contraception, pregnancy, childbirth and lactation, menstruation and premenstrual cycles, and the uterus, ovaries and breasts.
- WOMLM2.5 Describe how adolescence, pregnancy, breastfeeding, parenting, menopause and aging are natural events and not pathology.
- WOMLM2.6 Describe the psychosocial component of women's health.
- WOMLM2.7 Outline how forms of abuse, including physical, sexual, emotional, financial and psychological, impact on health.
- WOMLM2.8 Describe the importance of the role of the GP in maintaining and enhancing women's health and wellbeing while avoiding over-medicalisation.

### 3. Population health and the context of general practice

- WOMLM3.1 Describe the particular groups of women that are more likely to suffer health inequalities and describe the impact of these, including barriers to accessing care (eg. lack of availability of a culturally and/or gender appropriate primary health provider), reduced screening rates and increased health risks.
- WOMLM3.2 Describe prevention and screening strategies relevant to women and detail the evidence for their use (using the RACGP *Guidelines for preventive activities in general practice* and the National Health and Medical Research Council guidelines, if available).

### 4. Professional and ethical role

- WOMLM4.1 Describe the preference of some women to see a primary healthcare provider of a particular culture and/or gender, while also considering the need for all doctors to acquire and maintain skills in women's health.
- WOMLM4.2 Demonstrate respect for women's autonomy for health decisions.
- WOMLM4.3 Discuss and reflect on own values, attitudes and approach to ethical issues (eg. termination of pregnancy, contraception for minors, cosmetic surgery).
- WOMLM4.4 Describe the ethical and legal issues of women in Australia to access abortion services and the GP's professional obligation to be nonjudgmental when a woman seeks termination of pregnancy.
- WOMLM4.5 Develop competencies for a team approach to healthcare and inter-professional practice, specifically to enable continuity of care for women seeing more than one healthcare provider.

### 5. Organisational and legal dimensions

- WOMLM5.1 Describe the legal issues surrounding abortion, access to assisted reproductive technology and adoption, age of consent, and end-of-life decision making in Australia (as the laws may vary in each state or territory).

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

WOMLP1.1 Demonstrate the ability to meet all the objectives listed for medical students at a more complex level of skill in all areas.

### 2. Applied professional knowledge and skills

WOMLP2.1 Show competency in the skills of physical examination, in medically justified circumstances, that create a sense of comfort and safety for the patient.

WOMLP2.2 Demonstrate the ability to perform intimate examinations independently with sensitivity and care, allowing the woman to control the process including:

WOMLP2.2.1 cervical screening

WOMLP2.2.2 pelvic examination

WOMLP2.2.3 breast examination.

WOMLP2.3 Provide emotional support for the psychosocial component of women's health.

### 3. Population health and the context of general practice

WOMLP3.1 Describe the particular groups of women that are more likely to suffer health inequalities and describe the impact of these in the hospital setting, including barriers to accessing care (eg. lack of availability of a culturally and/or gender appropriate primary health provider), reduced screening rates and increased health risks.

### 4. Professional and ethical role

WOMLP4.1 Demonstrate willingness to arrange appropriate referral if own personal values prevent provision of a service, such as termination of pregnancy, contraception for minors, or cosmetic surgery.

### 5. Organisational and legal dimensions

WOMLP5.1 Describe the GP's role in issues relating to guardianship and informed consent for girls and women presenting to hospital for contraception, sterilisation or termination of pregnancy.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- WOMLV1.1 Demonstrate the ability to meet all the objectives listed for prevocational doctors (WOMLP) at a more complex level of skill in all areas and in the general practice setting.

### 2. Applied professional knowledge and skills

- WOMLV2.1 Understand and work with women's priorities for their health, including conflicting priorities that arise as a result of their role as carers.
- WOMLV2.2 Be able to pick up cues for a history of physical, sexual, emotional or financial abuse and acknowledge any subsequent psychological impact on the woman's health.

### 3. Population health and the context of general practice

- WOMLV3.1 Discuss the advantages and disadvantages of prevention and screening strategies with individual women and the evidence for their use (using the RACGP *Guidelines for preventive activities in general practice* and NHMRC guidelines, if available).
- WOMLV3.2 Understand the role of the GP in contributing to women's health in the broader community, including the ability to work with, and refer to, community women's health groups.

### 4. Professional and ethical role

- WOMLV4.1 Describe the role of the GP in advocacy for women's health such as human rights and women's health, social justice and social responses to violence against women, and facilitating access and equity with regard to service provision.

### 5. Organisational and legal dimensions

- WOMLV5.1 Examine how practice management issues impact on the provision of care to women, including the maintenance of confidentiality by all practice staff.
- WOMLV5.2 Describe the GP's legal obligation to ensure that follow up and recall systems for women's health screening and contraception are reliable and effective.
- WOMLV5.3 Outline legislation and policy relevant to women's health and how these relate to general practice, including mandatory reporting.
- WOMLV5.4 Understand the GP's role in advocacy and support for women who are discriminated against as a result of their gender, sexual orientation, ethnicity or other personal attribute.
- WOMLV5.5 Describe health and support services specifically targeted for women.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- WOMLC1.1 Demonstrate maintenance and ongoing development of communication skills specific to women's health in ongoing professional development needs.

### 2. Applied professional knowledge and skills

- WOMLC2.1 Demonstrate maintenance and ongoing development of professional knowledge and skills specific to women's health in ongoing professional development needs.
- WOMLC2.2 Understand and work with women's priorities for their health, including conflicting priorities that arise as a result of their role as carers.
- WOMLC2.3 Be able to pick up cues for a history of physical, sexual, emotional or financial abuse and acknowledge any subsequent psychological impact on health.

### 3. Population health and the context of general practice

- WOMLC3.1 Keep up-to-date with changes to prevention and screening guidelines and their evidence base.
- WOMLC3.2 Understand national and state women's health policies and apply these to general practice.
- WOMLC3.3 Demonstrate the ability to discuss the advantages and disadvantages of prevention and screening strategies with individual women, and the evidence for their use (using the RACGP *Guidelines for preventive activities in general practice* and NHMRC guidelines, if available).
- WOMLC3.4 Understand the GP's role in contributing to women's health in the broader community, including the ability to work with and refer to community women's health groups.

### 4. Professional and ethical role

- WOMLC4.1 Demonstrate how to apply the role in advocacy for women's health, such as human rights and women's health, social justice and social responses to violence against women, and facilitating access and equity with regard to service provision.

### 5. Organisational and legal dimensions

- WOMLC5.1 Demonstrate ongoing review of practice policies and procedures in identifying and dealing with barriers to women accessing healthcare.
- WOMLC5.2 Maintain current listings of health and support services specifically targeted for women.

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## *Acute serious illness and trauma*

### Contents

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Definition	213
Curriculum in practice	213
Rationale and general practice context	214
Training outcomes of the five domains of general practice	216
Learning objectives across the GP professional life	219
<i>Medical student</i>	219
<i>Prevocational doctor</i>	221
<i>Vocational registrar</i>	223
<i>Continuing professional development</i>	225
Reference	226

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## Definition

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Acute serious illness and traumatic injuries in general practice are conditions that require immediate care to relieve suffering and minimise morbidity and mortality risk. The core skills required for the competent general practice management of acute serious illness and trauma presentations are similar to those required to manage emergency department presentations, including major trauma.

Acute serious illness and trauma can occur in patients of any age. They may involve one or more body systems, and the context of the history may contribute to the required treatment response, for example, the collapsed patient or an accident site.

Acute serious illness can be classified by body systems including cardiovascular, respiratory, gastrointestinal, musculoskeletal, neurological, the immune system, and dermatological and metabolic conditions.

Presentations can also be classed into groups such as paediatric, obstetric, gynaecological, orthopaedic, surgical, general medical, psychiatric, ophthalmologic, eye and ear, and nose.

Traumatic conditions, such as accidents and injury to self and others, can generally be divided according to cause, for example, road trauma, environmental, toxicological, envenomation, assault and occupational injury.

## Curriculum in practice

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Typical cases that illustrate how the acute serious illness and trauma curriculum applies to general practice include:

- A friend of Betty, one of your elderly patients with asthma, telephoned saying that 'Betty is having breathing troubles and could you come and see her'. Betty's asthma is usually well controlled and she is up-to-date with her vaccinations, but you know there is a nasty viral respiratory tract infection going around. Her house is only a block away and you have just finished for the morning, so you are able to go straight there. When you arrive, Betty is sitting up in bed, cyanosed and too breathless to speak. Both women are highly anxious. The local ambulance is on another call and a replacement will not arrive for half an hour. You have not brought resuscitation equipment with you, but your doctor's bag is in the car.
- You are late home from work after a full day and looking forward to dinner and a good night's rest. As you drive past the football oval you see a car has taken the corner too fast and hit a power pole. The left front tyre appears to have run into a ditch, running the car off the road with the car momentarily flipping up against the pole, crushing the cabin area. You pull up behind it with your hazard lights and headlights on to illuminate the scene. You see a terrified primary school-aged child struggling to get out the smashed passenger window. Her mother is unconscious with her head hanging half out the driver's window, resting on the doorsill. There is barely an inch between the side of her head and the crushed roof and it is apparent that at the time of impact she sustained a head injury. She is cyanosed and has an obstructed airway.

## Rationale and general practice context

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Emergency life-threatening presentations in general practice are uncommon and the presentation of traumatic injuries to general practice has declined with hospital emergency departments being used as the first line of management for physical injuries.<sup>1</sup> This creates a professional development challenge because general practitioners need to maintain skill levels for the management of rare life-threatening conditions, as well as for the more common conditions that present to general practice.

General practitioners are more likely to see acute serious illness in the early stages when early recognition of warning signs, early investigation and referral may be life saving. Early treatment and patient education may help prevent disease exacerbations and avoid conditions deteriorating into more serious and potentially life-threatening conditions.

The diagnosis of acute serious illness may be clearer in patients presenting later in the natural history of the condition, but these patients may bypass general practice and go directly to an emergency department.

Trauma due to injury may vary in severity of presentation. Minor trauma such as musculoskeletal injuries and lacerations can be managed in general practice.

As with serious acute illness, patients with major trauma are less likely to present to general practice. They may go straight to an emergency department, although these may be staffed by GPs, especially in smaller or more remote rural hospitals.

General practitioners in rural and remote areas require a higher level of emergency care skills due to lower numbers of GPs, reduced access to specialist services, and the logistic and geographic difficulties of evacuating seriously ill patients. There is also a higher incidence of farming, mining, industrial and motor vehicle accidents, as well as greater access to firearms in isolated areas.

General practitioners may also be required to treat acute conditions outside of the practice or hospital setting, such as a collapse on a street or an accident site.

Acutely ill patients require stabilisation and transfer and admission to an acute care setting. This may involve advocating for the admission of the patient.

Continuity of care for seriously ill patients requires the use of handover skills.

Emergency situations may require GPs to provide clear instructions to staff, take control of situations and demonstrate the ability to lead the general practice or another team. This may occur outside the general practice setting, such as at an accident site, where leadership skills in sometimes chaotic and dangerous settings are critical to effective emergency management.

Personal safety issues for the GP and practice staff are of more concern in emergency situations, such as the management of acute psychiatric conditions, or at the scene of an accident.

General practitioners need to be prepared to manage complex medicolegal and ethical decisions in the acute care setting. These could include the management of the unconscious patient; the patient with impaired ability to give informed consent when ill; next-of-kin issues; and being sensitive to patient and next-of-kin choices, which may not accord with best possible treatment outcomes.

General practices also need to be able to prioritise patients according to treatment urgency. Within the context of regular general practice appointment systems, this will require the time management and organisational skills of both the GP and the general practice systems.

Acute serious illness may occur outside of usual practice hours. General practitioners require skills in after hours care, including telephone triage, to ensure that patients have access to appropriate levels of care.

The management of acute serious conditions has the potential to cause fear, fatigue and stress, and may be a significant risk to the doctor's own health. It may also impair clinical performance.

General practitioners need to ensure they have self care strategies in place to prevent and manage work related stress. They may also need to provide care for practice staff and others affected by emergency and acute care settings.

## Related curriculum areas

Acute serious illness and trauma can occur in any medical specialty area, although there is a common set of management skills required in managing any emergency situation.

For specific areas consult other curriculum statements including:

- *Aged care* for management of acute fractures in the elderly
- *Children and young people's health* for consent issues in an emergency if no accompanying parent is present
- *Chronic conditions* for medical emergencies
- *Drug and alcohol medicine* for drug overdose and trauma including legal implications
- *Teaching, mentoring and leadership in general practice*
- *Men's health* for traumatic injury
- *Mental health* for acute psychoses and follow up to manage post-traumatic stress disorder
- *Multicultural health* for the use of translators
- *Multidisciplinary care* for working in teams
- *Occupational health* for emergency workplace injuries
- *Pain management* for acute pain management principles
- *Quality and safety* for communication and handover issues
- *Rural health* for the range of skills required in this setting
- *Sports medicine* for acute musculoskeletal injuries
- *Women's health* for intimate partner abuse and pregnancy.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- ACUT1.1 Communicate clearly with patients and their carers when managing acute illness and trauma.
- ACUT1.2 Communicate sensitively with distressed patients and carers to allay anxiety during times of crises, especially in potentially life-threatening situations.
- ACUT1.3 Manage unconscious or severely ill patients when they have an impaired ability to provide informed consent.
- ACUT1.4 Communicate sensitively and with empathy when breaking bad news to patients and carers in times of bereavement, for issues around certifying death, and coroner and police involvement.
- ACUT1.5 Use appropriate telephone triage communication skills when providing emergency care including out-of-hours care.

## 2. Applied professional knowledge and skills

- ACUT2.1 Diagnose and immediately manage the range of life-threatening and emergency medical, surgical and psychiatric conditions occurring in the general practice setting.
- ACUT2.2 Recognise and evaluate acutely ill adults and children, and identify those patients who require immediate resuscitation and transfer to acute care settings.
- ACUT2.3 Provide the appropriate level of care when transferring severely ill patients from the general practice to the acute care setting.
- ACUT2.4 Identify which patients are more likely to become progressively ill, and provide management advice, including 'safety netting' and how to access care if their condition deteriorates.
- ACUT2.5 Use time management skills to prioritise patients according to the seriousness of the patient's condition.
- ACUT2.6 Maintain skill levels for the management of acute serious illness and trauma in the general practice setting, including those that are not common.
- ACUT2.7 Have the necessary skills to provide out-of-hours management of acute serious illness and trauma, which may occur when the practice is closed.
- ACUT2.8 Have an appropriate higher level of emergency general practice skills in particular settings, such as rural and remote areas.
- ACUT2.9 Diagnose cause of and certify death in a patient.
- ACUT2.10 Manage manipulative patients who request inappropriate emergency treatment.

### 3. Population health and the context of general practice

- ACUT3.1 Understand the range of presentations necessary to be able to identify and manage acute illness and identify potentially life-threatening situations including acute illness and trauma, which are not common in the general practice setting.
- ACUT3.2 Incorporate knowledge of cultural, occupational or other factors that may affect management of acute illness and trauma in the general practice setting.
- ACUT3.3 Educate patients and carers to help prevent disease exacerbations and the frequency of preventable emergency presentations (eg. the use of asthma medications to prevent asthma attacks, the use of seat belts in cars and not drink-driving).
- ACUT3.4 Be aware of the role of carers who may be involved at the time of the acutely ill person's presentation to the general practice, and the potential for conflict between patients and their relatives.

### 4. Professional and ethical role

- ACUT4.1 Respect patient choices and wishes when involved in complex ethical decisions that often occur during the management of acute illness and trauma.
- ACUT4.2 Initiate and make decisions regarding acute and emergency care in consultation with colleagues, when necessary.
- ACUT4.3 Demonstrate the leadership necessary in times of crises, such as the management of acute illness, including being able to provide clear direction and instruction to general practice staff in the management of acute illness, trauma and crisis situations.
- ACUT4.4 Advocate for patients who require admission to referral centres but who have been refused admission and have not yet been assessed by the centre.
- ACUT4.5 Ensure that self care strategies are in place to reduce the potential adverse health effects of caring for acutely ill patients and to prevent stress related performance impairment.
- ACUT4.6 Intervene and support colleagues who are affected by caring for acutely ill patients, when appropriate.
- ACUT4.7 Recognise ethical obligations in assisting in the management of acute illness and trauma, which may take place outside the general practice setting, such as at accident sites or in a patient's home.

### 5. Organisational and legal dimensions

- ACUT5.1 Prioritise patient consultation times according to the severity of the presenting illness, as acute serious conditions and trauma may present at unexpected times.
- ACUT5.2 Ensure that triage procedures are in place to ensure that seriously ill patients are seen first, and then managed accordingly in a timely manner.
- ACUT5.3 Ensure that clear communication occurs between the GP and other health workers within and outside the practice, for seriously ill patients needing referral and transfer from general practice to the acute care setting and during patient handover.
- ACUT5.4 Maintain the appropriate level of care during the transport of a patient from the general practice to the acute care setting.
- ACUT5.5 Ensure that acutely ill patients can access appropriate out-of-hours general practice care.

- ACUT5.6 Understand the resources required to be able to manage acute illness and trauma that may take place outside the general practice setting (eg. at accident sites or in a patient's home).
- ACUT5.7 Assess the potential of serious conditions that present significant personal security risks to self, staff, patients and others (eg. in an acutely disturbed psychiatric patient or at an accident site).
- ACUT5.8 Follow patients up after referral to the acute care setting to ensure continuity of care.
- ACUT5.9 Ensure appropriate handover procedures occur to ensure continuity of care for acutely ill patients.
- ACUT5.10 Exercise legal responsibilities such as using mental health regulations, certifying death or contacting the police and coroner.
- ACUT5.11 Exercise appropriate legal responsibilities for sick adults with an impaired ability to give informed consent and the special measures required when obtaining informed consent for treating an ill child.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- ACULM1.1 Describe why a patient centred approach is used in the management of acutely ill patients with diminished capacity for autonomous treatment decisions.
- ACULM1.2 Describe how communication in acutely ill patients may be influenced by age and other factors such as gender, ethnicity.
- ACULM1.3 Describe the principles involved in breaking bad news to patients and carers.

### 2. Applied professional knowledge and skills

- ACULM2.1 Describe the abnormal physiology and manifestations of critical illness.
- ACULM2.2 Identify how an acute illness may be an acute exacerbation of a chronic disease.
- ACULM2.3 Discuss the principles of medical triage.
- ACULM2.4 Describe why resuscitation may need to precede full assessment.
- ACULM2.5 Demonstrate the basic principles of airway management and ventilatory and circulatory support.
- ACULM2.6 Describe contemporary practices in basic and advanced life support.
- ACULM2.7 Demonstrate cardiopulmonary resuscitation.
- ACULM2.8 Describe how to assess patient vital signs.
- ACULM2.9 Describe the general clinical presentations of important acute serious illness and trauma.
- ACULM2.10 Describe the diagnosis and management of common and important acute serious illness and traumatic conditions including eye problems, chest pain, the collapsed patient, acute abdominal pain, respiratory problems (eg. asthma), major trauma (eg. face and spine), and common fractures (eg. hip fractures in older people, wrist fractures in the young).
- ACULM2.11 Demonstrate the safe practice of common clinical skills such as intramuscular injections, blood taking (including blood cultures, preparation of intravenous fluids), use of nebulisers, simple suture and current tetanus recommendations.

### 3. Population health and the context of general practice

- ACULM3.1 Describe the role of general practice in the management of acute illness and traumatic injury.
- ACULM3.2 Describe the patterns of presentation and care of acute serious illness and traumatic injury in the Australian healthcare setting.
- ACULM3.3 Describe the epidemiology of common presentations of acute serious illness and traumatic injury listed in the previous section: *Applied professional knowledge and skills*.

## 4. Professional and ethical role

- ACULM4.1 Discuss the impact of clinician fear, fatigue and stress associated with the treatment of seriously ill patients.
- ACULM4.2 Describe the personal health risks to doctors providing acute healthcare including personal safety, fatigue and stress, and the potential impact of practitioner impairment on patient health.
- ACULM4.3 Describe the professional obligations related to infection control in the acute healthcare setting.
- ACULM4.4 Describe the leadership role of clinicians and teamwork in the emergency and acute care setting.

## 5. Organisational and legal dimensions

- ACULM5.1 Discuss the role of informed consent in the treatment of acutely ill patients.
- ACULM5.2 Describe processes for obtaining informed consent in acutely ill minors.
- ACULM5.3 Describe potential threats to personal safety in the treatment of acutely ill patients.
- ACULM5.4 Describe the application of mental health legislation to patients with severe mental illness.
- ACULM5.5 Describe the laws that relate to certifying death.
- ACULM5.6 Describe mandatory reporting requirements, including when the coroner and police need to be notified in cases of death.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- ACULP1.1 Integrate a patient centred approach into the management of acutely ill patients who may have a decreased ability to make autonomous treatment decisions because of their illness.
- ACULP1.2 Integrate clear, culturally appropriate communication into the management of patients with acute illness and trauma.
- ACULP1.3 Demonstrate how to discuss serious illness and bereavement with patients and their carer, including breaking bad news.

### 2. Applied professional knowledge and skills

- ACULP2.1 Recognise and evaluate acutely ill patients.
- ACULP2.2 Identify which acutely ill patients require immediate resuscitation and when to call for assistance.
- ACULP2.3 Identify the clinical presentations of important acute serious illness and trauma.
- ACULP2.4 Demonstrate the assessment of a sick child.
- ACULP2.5 Accurately and efficiently diagnose and manage common and important acute serious illness and traumatic conditions, including eye problems, chest pain and respiratory problems (eg. asthma).
- ACULP2.6 Perform and interpret an electrocardiogram.
- ACULP2.7 Demonstrate cardiopulmonary resuscitation of children and adults, including the use of a defibrillator.
- ACULP2.8 Demonstrate how to control haemorrhage.
- ACULP2.9 Demonstrate how to suture a wound.
- ACULP2.10 Demonstrate how to use a nebuliser.
- ACULP2.11 Demonstrate male and female catheterisation.
- ACULP2.12 Demonstrate basic airway management and ventilatory and circulatory support.
- ACULP2.13 Diagnose cause of death and write death certificates.

### 3. Population health and the context of general practice

- ACULP3.1 Describe how cultural, occupational or other factors may affect patient management in the acute care setting.
- ACULP3.2 Demonstrate the ability to identify conflicts that may exist between patients and their carers, and act in the best interests of the patient.

## 4. Professional and ethical role

- ACULP4.1 Describe ethical complexities of caring for acutely ill patients.
- ACULP4.2 Describe the impact of acute illness and trauma on the ability to give informed consent.
- ACULP4.3 Participate in decision making and debriefing when ceasing resuscitation.
- ACULP4.4 Describe the leadership role that may be required of a doctor in emergency situations.
- ACULP4.5 Show an ability to work well within medical teams during emergencies.
- ACULP4.6 Outline measures that can be taken to promote clinician self care.
- ACULP4.7 Demonstrate how to recognise a clinician in difficulty.
- ACULP4.8 Describe how to consult colleagues about ethical concerns.

## 5. Organisational and legal dimensions

- ACULP5.1 Demonstrate accurate note taking and recording in emergency situations.
- ACULP5.2 Demonstrate how to give high priority to acutely ill patients.
- ACULP5.3 Demonstrate handover procedures for acutely ill patients.
- ACULP5.4 Demonstrate the ability to liaise patient care between hospitals and emergency services.
- ACULP5.5 Describe the management of the aggressive patient.
- ACULP5.6 Outline legal responsibilities regarding death certification, including when to involve the police.
- ACULP5.7 Describe how to apply mental health regulations for detaining acutely mentally ill patients.
- ACULP5.8 Describe the importance of maintaining or increasing the level of care while transferring the patient to the acute care setting.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- ACULV1.1 Demonstrate consultation skills appropriate to the management of acute illness and trauma in the general practice setting.
- ACULV1.2 Demonstrate clear communication with the patient and their family in the general practice setting during times of crisis.
- ACULV1.3 Demonstrate how to triage patients by telephone and decide whether to give telephone advice, arrange to see the patient at an appropriate time, or arrange emergency transfer.
- ACULV1.4 Describe how to sensitively communicate to patients and carers in life-threatening situations or at times of bereavement, including issues around certifying death and coroner and police involvement.

### 2. Applied professional knowledge and skills

- ACULV2.1 Demonstrate a range of essential procedures and skills for the management of acute illness and trauma presentations.
- ACULV2.2 Demonstrate decision making skills in the effective management of acute illness and trauma presentations.
- ACULV2.3 Identify which patients may become acutely ill and give management advice including how to access care if the patient's condition deteriorates.
- ACULV2.4 Demonstrate the management of common medical, surgical and psychiatric emergencies in the out-of-hours setting.
- ACULV2.5 Describe when resuscitation or intensive care may be inappropriate.
- ACULV2.6 Demonstrate the appropriate level of resuscitation and stabilisation required to transfer severely ill patients from the general practice setting to the acute care setting.
- ACULV2.7 Demonstrate essential advanced life support skills.
- ACULV2.8 Describe procedures for managing manipulative patients to prevent the inappropriate use of healthcare resources.

### 3. Population health and the context of general practice

- ACULV3.1 Demonstrate how to use patient education to help reduce the number and frequency of preventable presentations.
- ACULV3.2 Describe the needs of carers involved at the time of the acutely ill person's presentation in the general practice setting.

## 4. Professional and ethical role

- ACULV4.1 Demonstrate an ability to make complex ethical decisions in accordance with a patient's wishes.
- ACULV4.2 Demonstrate how to use a team based approach in the management of acute illness in the general practice setting, including how to provide leadership and how to follow instructions.
- ACULV4.3 Describe how to act as an advocate for patients who require admission to referral centres but who have been refused admission and have not yet been assessed.
- ACULV4.4 Describe the strategies in place to reduce the potential impact of providing acute care on the health of the GP, and how to help prevent stress related performance impairment.

## 5. Organisational and legal dimensions

- ACULV5.1 Demonstrate how to prioritise patient consultation times according to the severity of the presenting illness.
- ACULV5.2 Describe procedures for the appropriate referral and transfer of acutely ill patients from general practice to the acute care setting, including the role of effective communication with other health workers.
- ACULV5.3 Describe how acutely ill patients can access out-of-hours care in the general practice setting.
- ACULV5.4 Evaluate the awareness and management of the personal security risks to self, staff, patients and others (eg. at an accident site).
- ACULV5.5 Outline geographical and logistical transport issues for acutely unwell patients from rural and remote areas to tertiary centres.
- ACULV5.6 Describe how patients are followed up after transfer to the acute care setting.
- ACULV5.7 Describe the rehabilitation services available for patients who have suffered acute serious illness or trauma.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- ACULC1.1 Review special communication needs of practice populations (eg. the use of interpreters).
- ACULC1.2 Review educational needs to maintain communication skills.

### 2. Applied professional knowledge and skills

- ACULC2.1 Maintain competency in advanced life support skills and management of other acute serious illness, including through structured courses and professional development.
- ACULC2.2 Consider developing further advanced life support skills, especially in rural and remote areas.

### 3. Population health and the context of general practice

- ACULC3.1 Consider the use of patient education to prevent acute exacerbations of chronic conditions.
- ACULC3.2 Consider the need for differing or increased general practice in provisions of local emergency health services (eg. in rural and remote areas).
- ACULC3.3 Consider the role of the practice in the event of bioterrorism or other emergency.

### 4. Professional and ethical role

- ACULC4.1 Review skill levels in emergency medicine to ensure ongoing skill level maintenance.
- ACULC4.2 Review self care strategies.

### 5. Organisational and legal dimensions

- ACULC5.1 Review practice staff safety procedures and measures.
- ACULC5.2 Review practice staff capacity for dealing with acute situations.

## Reference

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1. Britt H, Charles J, Henderson J, et al. General practice activity in Australia 2000–01 to 2009–10: 10 year data tables. Canberra: Australian Institute of Health and Welfare; 2010.



## *Chronic conditions*

### **Contents**

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Definition	229
Curriculum in practice	229
Rationale and general practice context	230
Training outcomes of the five domains of general practice	233
Learning objectives across the GP professional life	237
<i>Medical student</i>	237
<i>Prevocational doctor</i>	240
<i>Vocational registrar</i>	243
<i>Continuing professional development</i>	246
References	247

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## Definition

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Chronic illness is the irreversible presence, accumulation or latency of disease states or impairments that involve the total human environment for supportive care, maintenance of function and prevention of further disability.<sup>1</sup>

Chronic conditions are defined by the World Health Organization as having one or more of the following characteristics: they are permanent, leave residual disability, are caused by nonreversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision and care.<sup>2</sup>

A chronic condition is defined as including any form of chronic illness, disease or symptom complex or disability, and is often of long duration and generally slow progression.<sup>2</sup>

A distinction needs to be made between chronic illness, which impacts on the wellbeing and the holistic functioning of the patient, and chronic disease, which may have little affect the day-to-day life of the patient other than the medical management required to prevent future mortality and morbidity. For instance, hypertension and hypercholesterolaemia are chronic diseases that require effective management and monitoring to prevent future cardiovascular events, but these diseases are unlikely to have as significant affect the daily wellbeing of the patient as for example, the chronic illness caused by, for example, rheumatoid arthritis.

## Curriculum in practice

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Typical presentations that illustrate how the chronic conditions curriculum applies to general practice include:

- Ted, 78 years of age, has ischaemic heart disease. who had a percutaneous stent inserted into his left anterior descending coronary artery in June 2004. Three years ago he suffered a myocardial infarct which resulted in congestive cardiac failure and a left ventricular ejection fraction of 42%. He has a past history of smoking and a long history of type 2 diabetes with hypercholesterolaemia and moderate hypertension. He was recently found to have albuminuria. He has atrial fibrillation for which he is taking warfarin but he has erratic INRs because, as a keen fisherman, he does not keep regular hours or meals.
- Emily, 58 years of age, is still working to support her youngest child who currently attends university. She presents for a 'check up' as she is feeling tired all the time and becomes short of breath when climbing stairs. At the time of menopause about 4 years ago, she had heavy periods and became mildly anaemic. This was treated with iron supplements for 3 months. You suspect that Emily may be anaemic again as she appears quite pale and you wonder if this might be due to the nonsteroidal anti-inflammatory drug that she takes intermittently for arthritis of the knees and wrists. Emily had a mammogram and Pap test about 18 months ago and is not taking any other medication, however you notice that she has lost about 5 kg since her last visit. The only other symptom she reports is long term constipation and haemorrhoids. Emily's haemoglobin returns as 8.5 g/dL and a subsequent colonoscopy finds a 6 cm poorly-differentiated adenocarcinoma of her ascending colon.

## Rationale and general practice context

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Chronic disease represents a substantial and increasing portion of healthcare expenditure and practitioner workloads.<sup>3</sup> The burden of chronic diseases is rapidly increasing worldwide, with chronic diseases contributing to approximately 60% all deaths globally.<sup>2</sup> The proportion of the burden of noncommunicable disease is rising with 80% of these deaths having associated modifiable risk factors.<sup>4</sup>

The rate of chronic problems managed by general practitioners has increased significantly between 2000–2001 and 2009–2010 from 48.2 to 54.1 chronic problems per 100 encounters,<sup>4</sup> resulting in an estimated additional 16 million chronic problems managed in general practice nationally in 2009–2010 compared with 2000–2001. Two chronic conditions, cardiovascular disease and cancer, constitute the two major causes of death in the Australian community.

Most working age Australians consider their health to be good, but results from the 2007–2008 Australian Bureau of Statistics National Health Survey reported that the commonest problems were eyesight (52% of the population), arthritis (15%), asthma (10%), hayfever and allergic rhinitis (15%) and hypertensive disease (9%). Other commonly reported conditions were back pain and disc disorders (14%) and deafness (10%).<sup>5</sup> The prevalence of these diseases increases with age and nearly all people in Australia aged 65 years and over report at least one long term condition.<sup>5</sup>

The National Public Health Partnership (NPHP) identifies the following chronic conditions as having the largest affect the burden of disease in Australia:<sup>6</sup>

- ischaemic heart disease (also known as coronary heart disease)
- stroke
- lung cancer
- colorectal cancer
- depression
- type 2 diabetes
- arthritis
- osteoporosis
- asthma
- chronic obstructive pulmonary disease (COPD)
- chronic kidney disease
- oral disease.

### The role of the GP

Both in Australia and internationally, the traditional medical and social care based on the disease centred acute hospital model has not met the needs of people with chronic illness, particularly with respect to psychological and long term care management.

General practice care models have been shifting in recent times from professional and service centred management to care that emphasises the individual managing and living with chronic disease, illness and disability. This has been identified as helping health outcomes.<sup>7</sup> In addition, the primary aim of chronic disease management shifts from cure to reducing the progression of symptoms and further complications.

Patients with chronic disease will have varying needs for medical management and support, depending on the disease type, the disability associated with that disease, and the stage of disease. Health system responses, including general practice, will need to match the appropriate level of healthcare needed.<sup>7</sup> In addition, the primary aim of chronic disease management shifts from cure to reducing the progression of symptoms and further complications.

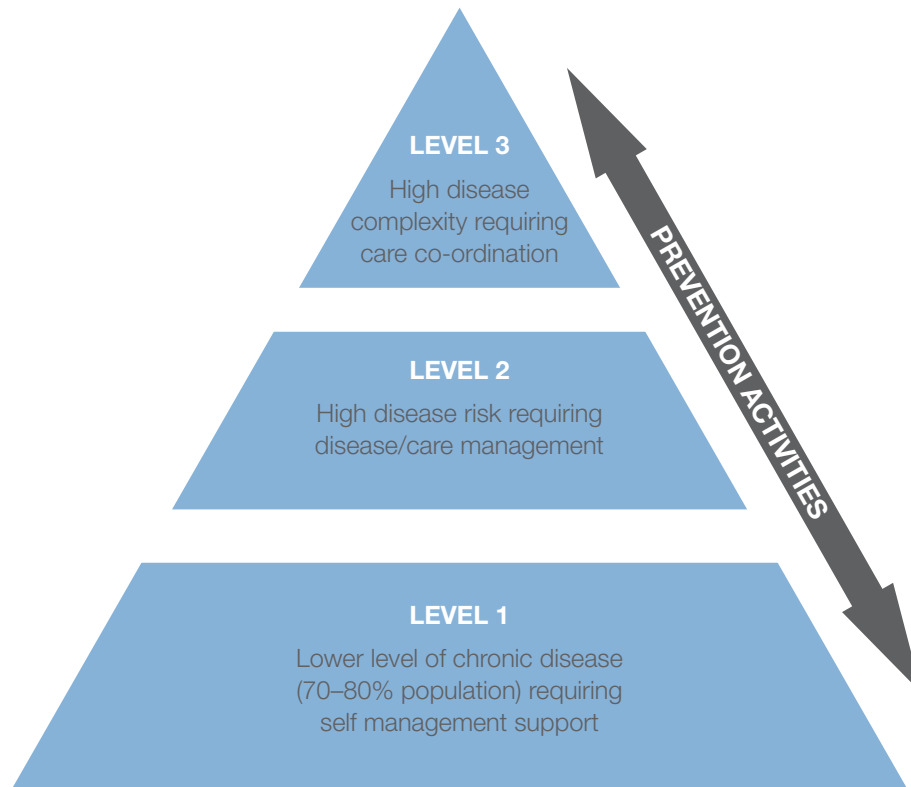


Figure 1. Levels of healthcare need to be matched to the care needs of chronic disease

## Lifestyle modification, general practice and chronic disease

There are many complex determinants of chronic disease, including social, economic and cultural factors. While some strategies are needed to attenuate the effects of these factors such as income support or governmental population health initiatives, modification of lifestyle factors is particularly important in managing chronic disease in general practice.

Important common lifestyle factors in the development of chronic disease identified for change in general practice are the SNAP risk factors: smoking, nutrition, alcohol and physical activity.<sup>8</sup> Lessening exposure to the risk factors of smoking and alcohol and promoting the benefits of good nutrition and physical activity, helps prevent and control chronic disease.

## A multidisciplinary approach to general practice chronic disease management

Care for patients with chronic illness is complex and needs to be supported by a systematic approach to self management, information management and multidisciplinary teamwork.<sup>7</sup>

The increasing prevalence of chronic disease has led to major changes in the methods of healthcare delivery and the role of different health professionals in delivering such care.

The role of the GP in chronic disease management varies over time but is central for most patients. General practitioners have ongoing relationships with their patients, which provides a central point of co-ordination for long term chronic disease management. Continuity of care, which is a key feature of general practice, has been shown to improve the quality of care and health outcomes for patients with chronic diseases.<sup>9</sup>

This continuity of care is particularly important in the significant proportion of patients who have more than one chronic disease, resulting in relatively complex disease management. General practitioners can co-ordinate care and are able to provide more holistic care for patients than the primarily disease focused care of the secondary and tertiary healthcare sector.

The healthcare team includes the general practice team (GPs and practice nurses), other primary healthcare professionals (eg. pharmacists, physiotherapists, psychologists) and healthcare professionals from the secondary sector.

In particular, practice nurses have an increasingly important role in the delivery of systematic care for chronic diseases in the general practice setting, and are similarly becoming better placed to participate in holistic rather than just disease-specific care.

In some locations and practices, for example in rural and remote settings, the boundaries between primary and secondary care may be less distinct, and the GP may be responsible for a greater proportion of in hospital patient care.

Patients and their carers have an extremely important role in the management of chronic diseases. Therefore supporting and educating patients in their self management is a critical role for GPs and general practice staff involved in the care of patients with chronic disease.

## Related curriculum areas

Refer also to the curriculum statements:

- *E-health*
- *Population health and public health*
- *Multidisciplinary care.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- CHRT1.1 Use appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) to gather additional history from patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRT1.2 Assess adherence to medication regimens and the ability to sympathetically ascertain from the patient or, where appropriate, family members, carers and/or other members of the multidisciplinary team, factors contributing to adherence.
- CHRT1.3 Explain the need for specific physical examinations to be made in the context of a specific consultation at one point of time and obtain patient consent to perform these examinations or, when appropriate, the consent of a family member or carer.
- CHRT1.4 Effectively communicate diagnoses of chronic diseases including comorbidities, acute exacerbations, complications to patients and, when appropriate, family members, carers and other members of the multidisciplinary team.
- CHRT1.5 Explain the role of tests and investigations (including pre- and post-test counselling) at different disease stages for prevalent chronic diseases, including at times of potential acute exacerbation or acute complication, and obtain patient consent to perform those tests/investigations or, when appropriate, that of a family member or carer. This should include explanations when tests and investigations are not required.
- CHRT1.6 Communicate test and investigation results in the context of particular chronic disease(s) to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRT1.7 Use a patient centred, supportive disease management approach and develop long term relationships that help patients with chronic conditions to take as much responsibility as possible for their own health outcomes.
- CHRT1.8 Understand the patient's knowledge, attitudes and meaning of their illness.
- CHRT1.9 Understand the importance of patient centred communication in improving health outcomes.
- CHRT1.10 Be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic diseases.
- CHRT1.11 Negotiate and document appropriate management plans to optimise patient wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to decisions regarding management.
- CHRT1.12 Appropriately refer to specialist physicians where necessary.
- CHRT1.13 Effectively communicate negotiated management plans for chronic diseases including comorbidities, acute exacerbations and/or complications of the diseases, when appropriate, to family members, carers and/or other members of the multidisciplinary team including specialist physicians.
- CHRT1.14 Maintain long term, supportive relationships with patients who do not respond to, or co-operate with, medical management.

- CHRT1.15 Use patient reminders (electronic or paper based) to facilitate appropriate proactive care.
- CHRT1.16 Use, when appropriate, tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change.
- CHRT1.17 Negotiate secondary and tertiary prevention strategies for patients with chronic diseases, taking into account the presence of risk factors, the stage of the disease and the potential for a changing risk/benefit ratio of medications or other treatments used for the disease over time.
- CHRT1.18 Assess the patient's understanding of their condition and educate them on how their condition may affect their quality of life.
- CHRT1.19 Assist patients to contact others with similar conditions and/or relevant support organisations.

## 2. Applied professional knowledge and skills

- CHRT2.1 Understand the principles of diagnosis, management and monitoring of chronic diseases and comorbidities and how these may relate to the disease course over time.
- CHRT2.2 Understand the natural history, prognosis, treatment and management of chronic conditions commonly encountered in general practice, including the ways in which some treatments may affect patients.
- CHRT2.3 Understand how the presence of comorbidities can affect disease prognosis and management.
- CHRT2.4 Understand the relevant anatomy, physiology, pathology and psychology appropriate to the management of common chronic conditions, the current best evidence for their management and the potential harms of pharmacological and nonpharmacological forms of treatment.
- CHRT2.5 Identify relevant risk factors for future health events in the context of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease.
- CHRT2.6 Identify medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases.
- CHRT2.7 Understand the importance, benefits and limitations of medical generalists in the provision of care for chronic conditions.
- CHRT2.8 Be able to take a history and examine patients for internal medicine and chronic conditions that are relevant to high quality general practice.
- CHRT2.9 Evaluate the physical, psychological and social levels of function and disability.
- CHRT2.10 Identify barriers that affect patients accessing optimal care for their chronic conditions and formulate practical strategies that they can adopt to help overcome these barriers.
- CHRT2.11 Use appropriately written records (eg. patient records including referral letters and correspondence, prescriptions, previous results of investigations) to gather relevant patient history.
- CHRT2.12 Identify and implement practical and pragmatic approaches to managing chronic diseases and comorbidity in the context of general practice that take into account the inherent uncertainty and complexity in biopsychosocial domains.
- CHRT2.13 Utilise techniques that support and maintain healthy lifestyle changes (eg. motivational interviewing, appropriate referral to other healthcare and specialist providers).

- CHRT2.14 Understand how to refer patients with chronic diseases to other members of the multidisciplinary team and liaise with team members regarding patient care.
- CHRT2.15 Use systematic approaches to case management, care co-ordination and advocacy (demonstrating an understanding of the need for continuity of care and remedial action as appropriate), including effective follow up and review processes for chronically ill patients.
- CHRT2.16 Critically reflect on emergent evidence based patient management information and implement appropriate modifications to existing management plans.
- CHRT2.17 Implement established methods to assure quality control such as periodic clinical audits to assure quality of care in patients with chronic disease.
- CHRT2.18 Embrace new technologies that have been demonstrated to improve health outcomes.

### 3. Population health and the context of general practice

- CHRT3.1 Understand the meaning of chronic illness and disease and the variable impact it has on the quality of life of an affected person, their family and the community.
- CHRT3.2 Understand the environmental, social, cultural and economic factors which contribute to the development and persistence of chronic conditions.
- CHRT3.3 Utilise the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRT3.4 Understand government policies and administrative requirements which relate to assisting people with chronic conditions, including chronic care Medicare item numbers.
- CHRT3.5 Help and support patients to overcome barriers related to their chronic condition (including stigmatisation, stoicism, social stereotyping and cultural norms).
- CHRT3.6 Understand the problems faced by patients (and their families and carers) in fulfilling underlying needs for better social support, coping skills and sense of patient autonomy and control.
- CHRT3.7 Understand the chronic health problems of specific community groups (eg. Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people with developmental disabilities).
- CHRT3.8 Use screening procedures to identify asymptomatic individuals at risk for common chronic diseases, and for those with existing chronic conditions (secondary prevention).
- CHRT3.9 Advocate for people with chronic conditions to support their access to services, benefits and entitlements.
- CHRT3.10 Understand the need to balance decisions that affect populations and the individual (eg. allocation of funding).
- CHRT3.11 Work effectively in a team, and where appropriate, as team leader to provide optimal care to people with chronic disease.
- CHRT3.12 Identify opportunities for prevention of chronic disease, especially within high risk groups.

## 4. Professional and ethical role

- CHRT4.1 Actively participate in multidisciplinary primary care teams.
- CHRT4.2 Understand the GP's role in shared and continuing care with hospital specialist teams.
- CHRT4.3 Provide support to patients and their families throughout the illness, and especially at times of crisis and change in the disease or treatment.
- CHRT4.4 Provide support at times of transition through the healthcare system (eg. on discharge from hospital).
- CHRT4.5 Implement methods for monitoring and evaluating quality long term care, and changing in response to feedback.
- CHRT4.6 Implement the ethical principles underlying the care of patients with chronic conditions in general practice (eg. concerning informed consent, privacy, autonomy, legitimacy and issues associated with end-of-life).
- CHRT4.7 Undertake home and nursing home visits and discuss the importance of these services in the management of chronic conditions.
- CHRT4.8 Actively develop team leadership skills.
- CHRT4.9 Effectively engage other members of the multidisciplinary team or wider health service networks in appropriate educative activities, including reinforcement of key messages.

## 5. Organisational and legal dimensions

- CHRT5.1 Develop, maintain, co-ordinate and evaluate disease management programs, including recall and prompted care systems, both within general practice and with multidisciplinary teams.
- CHRT5.2 Use and have readily accessible current evidence based guidelines for chronic disease management.
- CHRT5.3 Be aware of currently funded programs to assist in the management of chronic conditions (eg. National Chronic Disease Strategy).
- CHRT5.4 Provide timely, accurate and evidence based information to patients and carers on relevant chronic diseases.
- CHRT5.5 Use medical record systems appropriate to the care of patients with chronic conditions (eg. effective long term follow up, tracking and prompted systematic periodic review).
- CHRT5.6 Have strategies for time management, taking into consideration heavy demands on time and effort when managing complex medical problems and chronically ill patients.
- CHRT5.7 Use modern medical information systems effectively to assist in the prevention, diagnosis and management of chronic conditions.
- CHRT5.8 Be aware of ethical considerations in team approaches to healthcare (eg. sharing of health records).
- CHRT5.9 Be able to discuss the legal and advocacy aspects of chronic conditions (eg. certification, confidentiality, legal report writing, legal requirements of prescribing and refusal, withholding and withdrawal of treatment).
- CHRT5.10 Understand the full potential of computer records and e-health measures in disease management and prevention, including the use of electronic communication between other healthcare providers.
- CHRT5.11 Understand the importance of involving practice staff in the care of people with chronic disease, and their carers.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- CHRLM1.1 Describe the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questioning, reflection, summarising) to gather additional history from patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLM1.2 Outline the assessment of adherence to medication regimens and sympathetically ascertain from the patient or, where appropriate, family members, carers and/or other members of the multidisciplinary team factors contributing to adherence.
- CHRLM1.3 Explain the need for specific physical examinations to be made in the context of a specific consultation at one point of time and obtain the patient's consent or, where appropriate, the consent of family members or carers to perform those examinations.
- CHRLM1.4 Outline effective communication of diagnoses of chronic diseases including comorbidities, acute exacerbations and/or acute complications of the disease to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRLM1.5 Outline the role of indicated tests and investigations (including pre- and post-test counselling) at different time points in the disease journey for prevalent chronic diseases (including at times of potential acute exacerbation or acute complication) and obtain the patient's consent or, where appropriate, the consent of family members or carers to perform those tests or investigations. Outline the same for tests and investigations that are not indicated.
- CHRLM1.6 Outline principles for communicating test and investigation results in the context of particular chronic diseases to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRLM1.7 Describe the use of a patient centred, supportive approach and develop ongoing relationships that help patients with chronic conditions to take as much responsibility as possible for their own health outcomes.
- CHRLM1.8 Describe the role of gaining an understanding of the patient's knowledge, attitudes and meaning of their illness.
- CHRLM1.9 Describe the use of patient centred communication in improving chronic disease health outcomes.
- CHRLM1.10 Describe the principles in negotiating and documenting appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease outcomes, emphasising a shared approach to decision making.
- CHRLM1.11 Describe attitudes and behaviours related to chronic conditions that may be barriers to positive health outcomes, including stigmatisation, stoicism, social stereotyping and cultural norms.

## 2. Applied professional knowledge and skills

- CHRLM2.1 Describe relevant history and examination skills for high quality management of internal medicine and chronic conditions.
- CHRLM2.2 Describe the principles of diagnosis, management and monitoring of chronic diseases and comorbidities and how these may relate to the disease course over time.
- CHRLM2.3 Outline the natural history, prognosis, treatment and management of the chronic conditions commonly encountered in general practice, including the differing ways in which treatments may affect some people.
- CHRLM2.4 Describe how the presence of comorbidities can affect disease prognosis and management.
- CHRLM2.5 Describe various physical, psychological and social levels of function and disability.
- CHRLM2.6 Outline the relevant anatomy, physiology, pathology and psychology appropriate to the management of common chronic conditions, the current best evidence for their management and the potential harms of pharmacological and nonpharmacological forms of treatment.
- CHRLM2.7 Describe the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease.
- CHRLM2.8 Describe systematic approaches to case management, care coordination and advocacy, including effective follow up and review processes for chronically ill patients.
- CHRLM2.9 Describe the physical and mental status of patients with chronic conditions.
- CHRLM2.10 Describe the appropriate use of tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control.

## 3. Population health and the context of general practice

- CHRLM3.1 Outline the meaning of chronic illness and disease, and the variable impact it has on the quality of life of the patient, their family, and the community.
- CHRLM3.2 Describe appropriate screening procedures required to identify asymptomatic individuals, individuals at risk of common chronic diseases, and those who already have chronic conditions (secondary prevention).
- CHRLM3.3 Describe the use of evidence based guidelines for chronic disease management.
- CHRLM3.4 Describe barriers that affect patients accessing optimal care for chronic conditions and practical strategies that can be adopted to overcome these barriers.
- CHRLM3.5 Describe the environmental, social, cultural and economic factors which contribute to the development and persistence of chronic conditions.
- CHRLM3.6 Describe the problems faced by patients (and their families and carers) in fulfilling underlying needs for better social support, coping skills and sense of patient autonomy and control.
- CHRLM3.7 Outline the chronic health problems of specific community groups (eg. Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people with developmental disabilities).
- CHRLM3.8 Outline the balancing of policy decisions that affect populations and the individual (eg. allocation of funding).

## 4. Professional and ethical role

- CHRLM4.1 Outline how to provide support at times of crisis and transition (eg. at time of diagnosis).
- CHRLM4.2 Describe the GP's role as part of a multidisciplinary team in providing optimal care to people with a chronic disease in the primary care setting.
- CHRLM4.3 Outline the ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy and issues associated with end-of-life) within the hospital setting.

## 5. Organisational and legal dimensions

- CHRLM5.1 Identify and describe the medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases.
- CHRLM5.2 Describe methods of managing patients with chronic disease.
- CHRLM5.3 Describe the full potential of computer records in disease management and prevention, including the use of electronic communication between other healthcare providers and patient recall systems.
- CHRLM5.4 Describe the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRLM5.5 Describe the role of assisting patients to contact others with similar conditions and relevant support organisations, such as self help groups.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- CHRLP1.1 Demonstrate the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) in the hospital setting to gather additional history from patients and, when appropriate, from family members, carers, and other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLP1.2 Demonstrate the nonjudgmental assessment of adherence to medication regimens and sympathetically ascertain from the patient, or where appropriate, family members, carers, and/or other members of the multidisciplinary team, factors contributing to adherence in the hospital setting.
- CHRLP1.3 Demonstrate the ability to effectively communicate diagnoses of chronic disease(s) including comorbidities, acute exacerbations and/or acute complications of the diseases to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team.
- CHRLP1.4 Demonstrate the ability to explain the role of indicated tests and investigations (including pre- and post-test counselling) at different time-points in the disease course for prevalent chronic diseases (including at times of potential acute exacerbation or acute complication) and obtain patient consent (or the consent of a family member or carer where appropriate) to perform those tests/investigations. Demonstrate the same for tests and investigations that are not indicated.
- CHRLP1.5 Demonstrate the ability for communicating test and investigation results in the context of particular chronic diseases to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team in the hospital setting.
- CHRLP1.6 Demonstrate use of a patient centred, supportive approach and develop ongoing relationships that help patients with chronic conditions to take as much responsibility as possible for their own chronic disease outcomes.
- CHRLP1.7 Demonstrate an ability to gain an understanding of the patient's knowledge, attitudes and meaning of their illness in the hospital setting.
- CHRLP1.8 Demonstrate the use of patient centred communication in improving chronic disease health outcomes in the hospital setting.
- CHRLP1.9 Demonstrate the negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the hospital setting.
- CHRLP1.10 Outline approaches for the long term management of patients who do not respond to, or co-operate with, medical management.

## 2. Applied professional knowledge and skills

- CHRLP2.1 Demonstrate history and examination skills for internal medicine and chronic conditions that are relevant to high quality hospital based medicine.
- CHRLP2.2 Demonstrate the ability to assess physical, psychological and social levels of function and disability in the hospital setting.
- CHRLP2.3 Demonstrate the appropriate use of tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control in the hospital setting.
- CHRLP2.4 Demonstrate the ability to be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic conditions in the hospital setting.
- CHRLP2.5 Demonstrate support for overcoming barriers to positive health outcomes for people with chronic attitudes and behaviours including stigmatisation, stoicism, social stereotyping and cultural norms.
- CHRLP2.6 Demonstrate the ability to identify the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease in the hospital setting.
- CHRLP2.7 Demonstrate use of all information sources (eg. patient records, including referral letters, prescriptions, previous results of tests and investigations to gather relevant patient history) when formulating management plans.
- CHRLP2.8 Demonstrate systematic approaches to case management, care co-ordination and advocacy, including effective follow up and review processes for chronically ill patients in the hospital setting.

## 3. Population health and the context of general practice

- CHRLP3.1 Demonstrate the ability to identify barriers impacting on patients' accessing optimal care for their chronic conditions in the hospital setting and practical strategies patients can adopt to overcome these barriers.
- CHRLP3.2 Demonstrate appropriate screening procedures required to identify asymptomatic individuals at risk of common chronic diseases, and those who already have chronic conditions (secondary prevention).
- CHRLP3.3 Review opportunities for the prevention of chronic disease, especially among high risk groups.

## 4. Professional and ethical role

- CHRLP4.1 Demonstrate the capacity to work effectively in a team and as a team leader to provide optimal care to people with a chronic disease.
- CHRLP4.2 Provide support at times of transition through the healthcare system (eg. on discharge from hospital).
- CHRLP4.3 Describe the ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy, and issues associated with end-of-life) within the hospital setting.
- CHRLP4.4 Be aware of ethical considerations of team approaches to healthcare (eg. sharing of health records).
- CHRLP4.5 Describe the legal and advocacy aspects of chronic conditions (eg. certification, confidentiality, legal report writing, legal requirements of prescribing and refusal, withholding and withdrawal of treatment).

## 5. Organisational and legal dimensions

- CHRLP5.1 Demonstrate the use of evidence based guidelines for chronic disease management.
- CHRLP5.2 Identify and describe the relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases in the hospital setting.
- CHRLP5.3 Demonstrate the use of the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRLP5.4 Describe how hospital links to general practice in methods of managing patients with chronic disease.
- CHRLP5.5 Demonstrate appropriate and effective referral and liaison of patients with chronic diseases to other members of the multidisciplinary team in the hospital setting.
- CHRLP5.6 Demonstrate the appropriate referral of assisting patients to contact others with similar conditions and relevant support organisations, such as self help groups, in the hospital setting.
- CHRLP5.7 Discuss strategies for time management, taking into consideration demands on time and effort when managing complex medical problems and chronically ill patients.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- CHRLV1.1 Demonstrate the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) in the general practice setting to gather additional history from patients, and, when appropriate, from family members, carers, and other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLV1.2 Demonstrate the nonjudgmental assessment of adherence to medication regimens and sympathetically ascertain from the patient or, where appropriate, family members, carers, and/or other members of the multidisciplinary team, factors contributing to adherence in the general practice setting.
- CHRLV1.3 Demonstrate the ability for communicating test and investigation results in the context of particular chronic disease(s) to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team in the general practice setting.
- CHRLV1.4 Demonstrate use of a patient centred, supportive approach and discuss how to develop long term relationships to help patients with chronic conditions take as much responsibility as possible for their own chronic disease health outcomes in the general practice setting.
- CHRLV1.5 Demonstrate the ability to gain an understanding of the patient's knowledge, attitudes and meaning of their illness in the general practice setting.
- CHRLV1.6 Demonstrate use of patient centred communication in improving chronic disease health outcomes in the general practice setting.
- CHRLV1.7 Demonstrate the negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the general practice setting.
- CHRLV1.8 Demonstrate systematic approaches to case management, care co-ordination and advocacy, including effective follow up and review processes for chronically ill patients in the general practice setting.
- CHRLV1.9 Demonstrate the ability to perform appropriate medical procedures for chronic disease management in the general practice setting.
- CHRLV1.10 Demonstrate skills to support patients who do not respond to, or co-operate with, medical management in the general practice setting.

## 2. Applied professional knowledge and skills

- CHRLV2.1 Demonstrate history and examination skills for internal medicine and chronic conditions appropriate to high quality general practice.
- CHRLV2.2 Demonstrate the ability to identify the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease in the general practice setting.
- CHRLV2.3 Demonstrate negotiation of secondary and tertiary prevention strategies for patients with chronic disease, taking into account the presence of risk factors, disease stage and potential for changing risk/benefit ratio of medications or other treatments used over time in the general practice setting.
- CHRLV2.4 Demonstrate the appropriate use of tools to assess a patient's readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control in the general practice setting.
- CHRLV2.5 Demonstrate the ability to assess various physical, psychological and social levels of function and disability in the general practice setting.
- CHRLV2.6 Demonstrate the ability to identify and implement practical and pragmatic approaches to managing chronic diseases and comorbidities that take explicit account of the uncertainties and complexities across biopsychosocial domains in the general practice setting.
- CHRLV2.7 Demonstrate the use of techniques to support and maintain healthy lifestyle changes (eg. motivational interviewing, appropriate referral to other primary healthcare providers and/or specialist providers).
- CHRLV2.8 Demonstrate the ability to be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic conditions in the general practice setting.

## 3. Population health and the context of general practice

- CHRLV3.1 Outline current government chronic disease program policies which relate to assisting people with chronic conditions in the general practice setting.
- CHRLV3.2 Demonstrate the ability to identify barriers impacting on patients' access to optimal care for their chronic conditions in the general practice setting and practical strategies patients can adopt to overcome these barriers.
- CHRLV3.3 Describe appropriate screening procedures required to identify asymptomatic individuals, individuals at risk for common chronic diseases, and those who already have chronic conditions (secondary prevention) in the primary care setting.

## 4. Professional and ethical role

- CHRLV4.1 Demonstrate the provision of support at times of crisis and transition (eg. at time of diagnosis).
- CHRLV4.2 Demonstrate the capacity to work effectively, either within a team or as a team leader to provide optimal care to people with chronic disease in the primary care setting.
- CHRLV4.3 Demonstrate application of ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy, and issues associated with end-of-life).
- CHRLV4.4 Demonstrate the review of new technologies that have been shown to improve health outcomes for people with chronic conditions.

## 5. Organisational and legal dimensions

- CHRLV5.1 Demonstrate methods of managing patients with chronic disease.
- CHRLV5.2 Demonstrate ready access to and use of evidence based guidelines for chronic disease management.
- CHRLV5.3 Identify and describe the roles of relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases in the general practice setting.
- CHRLV5.4 Demonstrate the use of the various health and community resources available for the support, prevention, diagnosis, and management of chronic conditions available to your general practice population.
- CHRLV5.5 Demonstrate appropriate and effective referral and liaison of patients with chronic diseases to other members of the multidisciplinary team in the general practice setting.
- CHRLV5.6 Incorporate new technologies that have been demonstrated to improve health outcomes for people with chronic conditions.
- CHRLV5.7 Demonstrate advocacy for people with chronic conditions to support their access to services, benefits and entitlements in the primary care setting.
- CHRLV5.8 Outline the management of chronic conditions as they apply to house and nursing home visits.
- CHRLV5.9 Demonstrate how to appropriately assist patients to contact others with similar conditions and relevant support organisations, such as self help groups, in the general practice setting.
- CHRLV5.10 Demonstrate use of government policies and administrative requirements that relate to assisting people with chronic conditions.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- CHRLC1.1 Outline the general practice systems relating to the maintenance, coordination and evaluation of disease management programs, including recall and prompted care systems and involvement of multidisciplinary teams.
- CHRLC1.2 Demonstrate the ongoing negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the general practice setting.
- CHRLC1.3 Review processes for supporting patients who do not respond to, or co-operate with, medical management in the general practice setting.

### 2. Applied professional knowledge and skills

- CHRLC2.1 Demonstrate critical reflection and implement modifications to approaches for general practice chronic disease management as new evidence based patient management approaches emerge.

### 3. Population health and the context of general practice

- CHRLC3. 1 Demonstrate review of government chronic disease programs and policies that relate to assisting people with chronic conditions in the general practice setting.

### 4. Professional and ethical role

- CHRLC4.1 Consider ongoing review of leadership skills with respect to multidisciplinary team management and chronic conditions.
- CHRLC4.2 Demonstrate the role in shared care and ongoing care with hospital specialist teams.

### 5. Organisational and legal dimensions

- CHRLC5.1 Demonstrate ongoing review of the relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases, within your general practice and local community setting.
- CHRLC5.2 Demonstrate regular review of health and community resources available for the support, prevention, diagnosis and management of chronic conditions available to your general practice population.
- CHRLC5.3 Demonstrate the implementation of methods for monitoring and evaluating quality long term care and responsiveness to feedback.

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## *Dermatology*

### **Contents**

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Definition	251
Curriculum in practice	251
Rationale and general practice context	252
Training outcomes of the five domains of general practice	253
Learning objectives across the GP professional life	255
<i>Medical student</i>	255
<i>Prevocational doctor</i>	257
<i>Vocational registrar</i>	259
<i>Continuing professional development</i>	261
References	263

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## Definition

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General practice dermatology refers to the assessment, treatment and referral of disorders that affect the skin, nail, hair and mucous membranes.

## Curriculum in practice

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Typical cases that illustrate how the dermatology curriculum applies to general practice include:

- Ian, 58 years of age, is a pig farmer. He rarely presents to the practice but today he comes in nursing one hand, which he has wrapped in a bandage. He can't remember injuring the hand, but it has now developed a large vesiculated lesion on the right thumb. Ian says he cannot work because his hand is too tender and that last night he felt 'shivery' cold. Today he is febrile with tender axillary nodes. Ian is surprised how rapidly the lesion developed, saying it was barely visible just 3 days ago. A culture is obtained and the result is *Streptococcus pyogenes*. Ian wants to know how long it will take to recover.
- Jack, 17 years of age, is a high school student. He presents for review of a rash on his face that 'just won't get better'. The rash started just a few days after returning from an intensive training camp and began with a few spots on his forehead which then spread rapidly to cover the right cheek. He thought it might be a friction rash from the mats they used at the camp. He had tried topical antiseptic creams without success. Jack was commenced on antibiotics a week ago, but today, the lesions appear to be more ulcerated in nature and consistent with *Herpes gladiatorum*.
- Katie, 6 years of age, has been sent home from school because she has an itchy rash. The school were worried it might be scabies. The rash is dry and scaly and predominantly involves the antecubital and popliteal fossa. There is hypo-pigmentation of the skin and her mother reports that Katie has had it on and off since she was a baby. There is a family history of atopy.

## Rationale and general practice context

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Skin conditions account for 14.8 out of every 100 patient encounters in general practice and 10.4% of the total reasons for encounters, making them one of the most common presentations in Australian general practice.<sup>1</sup> In addition to being a major source of patient morbidity, skin conditions can be the first presentation of serious systemic disease, including infection and malignancy, with skin cancers being the second commonest reason for medical specialist referral in general practice.<sup>1</sup> Skin cancers are a major and increasing source of premature death in Australia,<sup>2,3</sup> highlighting the importance of prompt diagnosis and management.

While each patient presenting with a skin condition is unique, some significant skin conditions are more common among particular patient groups. For example, Aboriginal and Torres Strait Islander Australians are prone to streptococcal skin disease and to secondary renal disease. Also, the vulnerability to skin cancers, including melanoma, is increased in the highly immunosuppressed, especially transplant recipients.

General practitioners also see skin conditions or dermatological manifestations of systemic diseases that, although uncommon in Australia, are seen in travellers, refugees and other people who have been to areas outside of Australia.

General practice has a significant role in participating in public health measures aimed at reducing the significant health burden of adverse outcomes, including patient education, about the avoidance of environmental hazards that may cause skin problems and other public health measures such as disease notification. This includes screening for skin cancers according to evidence based guidelines and targeting specific high risk populations.

### Related curriculum areas

Refer also to the curriculum statements:

- *Procedural skills* for general principles of dermatological procedures
- *Quality and safety* for ensuring patient safety.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- DERT1.1 Must be able to take an accurate and complete history, as skin conditions may reflect serious systemic or psychiatric disturbance. This incorporates the need to assess skin diseases that may be influenced by lifestyle, work, psychological state, cultural practices, ethnicity, geography and travel.
- DERT1.2 Need to assess how skin conditions affect the patient's family and community.
- DERT1.3 Need to provide ongoing full assessment of skin conditions, especially chronic conditions, with close attention to the long term physical, psychological and social impact of the disease on the patient. This includes the patient's own conception of their disease, which can markedly affect management and outcomes.

## 2. Applied professional knowledge and skills

- DERT2.1 Require knowledge of regional anatomy relevant to skin surgery. Need to be able to describe skin lesions using standard dermatological terms.
- DERT2.2 Require knowledge of clinical and historical features of major common diseases including:
- DERT2.2.1 eczema: atopic, contact and seborrhoeic
  - DERT2.2.2 psoriasis
  - DERT2.2.3 acne
  - DERT2.2.4 rosacea
  - DERT2.2.5 urticaria
  - DERT2.2.6 bacterial infections: cellulitis, erysipelas, impetigo
  - DERT2.2.7 viral infections: herpes simplex, herpes zoster, warts, pityriasis rosea, exanthems, enanthems
  - DERT2.2.8 fungal infections: dermatophytes, pityriasis versicolor, candidiasis
  - DERT2.2.9 insect infections: lice, scabies
  - DERT2.2.10 benign growths: epidermoid cysts, seborrhoeic keratoses, solar lentigos
  - DERT2.2.11 malignancy and premalignant conditions: solar keratosis, basal cell carcinoma, squamous cell carcinoma, Bowen's disease (squamous carcinoma in situ) keratoacanthoma, melanoma
  - DERT2.2.12 pruritus
  - DERT2.2.13 hair diseases: alopecia areata, androgenic alopecia, telogen effluvium
  - DERT2.2.14 nail diseases: fungal, psoriatic, neoplastic nail disease
  - DERT2.2.15 ulcers: including venous, arterial, malignant and pressure ulcers
  - DERT2.2.16 systemic lupus erythematosus, lichen planus, purpura, keratosis pilaris, sarcoidosis.
- DERT2.3 Perform a competent skin examination, choose appropriate investigations and perform appropriate dermatological procedures. Such procedures may include:
- DERT2.3.1 biopsy: shave, punch, and excisional biopsy
  - DERT2.3.2 cryotherapy
  - DERT2.3.3 diathermy
  - DERT2.3.4 curettage
  - DERT2.3.5 skin and nail scrapings for fungal disease
  - DERT2.3.6 skin swabs for bacterial or viral disease
  - DERT2.3.7 dermoscopy.

- DERT2.4** Must be able to recognise life threatening dermatological emergencies including:
- DERT2.4.1** meningococcal septicaemia
  - DERT2.4.2** ocular herpes simplex and zoster
  - DERT2.4.3** toxic epidermal necrolysis and Stevens-Johnson syndrome
  - DERT2.4.4** erythroderma: exfoliative dermatitis and pustular psoriasis
  - DERT2.4.5** Kawasaki disease
  - DERT2.4.6** scalded skin syndrome
  - DERT2.4.7** angioedema/anaphylaxis
  - DERT2.4.8** pemphigus vulgaris
  - DERT2.4.9** necrotising fasciitis
  - DERT2.4.10** polyarteritis nodosum
  - DERT2.4.11** eczema herpeticum
  - DERT2.4.12** periorbital cellulitis
  - DERT2.4.13** spider and snake bites.
- DERT2.5** Recognise unusual skin conditions or dermatological manifestations of systemic diseases.
- DERT2.6** Recognise skin conditions related to drug reactions and environmental exposures.

### 3. Population health and the context of general practice

- DERT3.1** Educate patients about the avoidance of environmental hazards such as solar radiation, workplace or household exposures that may cause skin problems.
- DERT3.2** Practise public health measures that aim to reduce the health burden of adverse outcomes such as disease notification requirements.
- DERT3.3** Screen for skin cancers according to evidence based guidelines including targeting specific high risk populations.
- DERT3.4** Integrate knowledge of significant skin conditions which are more common among particular groups within Australia including Indigenous Australians.
- DERT3.5** Recognise unusual skin conditions or dermatological manifestations of systemic diseases uncommon in Australia that may present in travellers, refugees or other people who have been in areas outside of Australia.

### 4. Professional and ethical role

- DERT4.1** Manage skin conditions using a team approach that involves specialist colleagues in dermatology, plastic surgery or skilled nursing staff.
- DERT4.2** Acknowledge the limitations for treating dermatological conditions within general practice and refer patients in a timely and appropriate manner when necessary.
- DERT4.3** Use an empathetic and nonjudgmental approach that recognises the potential for psychological distress from skin conditions for the patient and others, including the potential lifelong misery and stigma of some skin conditions such as visible birthmarks, psoriasis, alopecia and acne.

### 5. Organisational and legal dimensions

- DERT5.1** Ensure that organisational strategies are in place for referring patients unsuitable for general practice management.
- DERT5.2** Ensure the accurate documentation of examinations, care and patient outcomes.
- DERT5.3** Ensure that the practice complies with the standards required for practical procedures (eg. infection control).

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- DERLM1.1 Demonstrate how to establish rapport with a patient, carer and/or parent.
- DERLM1.2 Describe the impact of skin disease on work, daily life and psychological wellbeing.
- DERLM1.3 Demonstrate how to take a history of skin problems without neglecting other health issues.
- DERLM1.4 Describe patient concerns and understanding about their skin problem.
- DERLM1.5 Describe the impact of patient concerns and understanding on the individual and their family.
- DERLM1.6 Demonstrate patient friendly explanations of the pathological process, natural history and treatment of the patient's condition.

### 2. Applied professional knowledge and skills

- DERLM2.1 Describe skin anatomy, physiology and function.
- DERLM2.2 Describe the manner in which skin disease manifests.
- DERLM2.3 Describe the aetiology, symptoms, examination and investigative techniques required to diagnose and manage common dermatological diseases.
- DERLM2.4 Identify skin signs of serious or life threatening illness including HIV infection.
- DERLM2.5 Demonstrate the ability to clearly summarise the history of a presenting skin problem.
- DERLM2.6 Describe the skin condition using standard dermatological terms.
- DERLM2.7 Demonstrate how to perform a sensitive, thorough skin examination which includes hair, nails and mucous membranes.
- DERLM2.8 Describe the investigative techniques useful for diagnosis.
- DERLM2.9 Outline the commonly used topical and systemic therapies available for common skin conditions.
- DERLM2.10 Describe the major side effects of the most commonly used medications, especially topical steroids.
- DERLM2.11 Outline the principles of basic skin surgery.
- DERLM2.12 Describe the difference between 'cure' and 'control' of skin disease.

### 3. Population health and the context of general practice

- DERLM3.1 Describe the infectious nature of some skin diseases and the infection control measures needed for patients, siblings, parents and the school or work environment.
- DERLM3.2 Describe how some occupations, hobbies and lifestyle choices influence and cause some skin diseases.
- DERLM3.3 Outline the genetics and familial aspects of some skin diseases including atopic dermatitis and psoriasis.
- DERLM3.4 Describe the impact of complementary therapies, such as herbal cream allergies, on skin conditions (eg. calendula cream in eczema can cause severe allergic reaction).
- DERLM3.5 Describe screening for skin cancers according to evidence based guidelines including targeting specific high risk populations.
- DERLM3.6 Describe the goals and relevance of public health campaigns (eg. 'slip, slop, slap').

### 4. Professional and ethical role

- DERLM4.1 Demonstrate the skills needed to explain conditions, their treatment and prognosis to colleagues and patients.
- DERLM4.2 Demonstrate empathy for people with skin diseases.
- DERLM4.3 Recognise that not all treatments are available, cost effective or equally preferred by all patients with the same skin condition.

### 5. Organisational and legal dimensions

- DERLM5.1 Describe the importance of informed consent for procedures.
- DERLM5.2 Describe the need for accurate and contemporaneous notes for skin conditions.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- DERLP1.1 Describe the patient's experience of the skin disease.
- DERLP1.2 Integrate a comprehensive patient centred approach into the assessment and management of people with skin disease.

### 2. Applied professional knowledge and skills

- DERLP2.1 Distinguish between what is primarily a skin disease and a dermatological manifestation of systemic disease (eg. a face rash may be a manifestation of systemic lupus erythematosus).
- DERLP2.2 Manage emergency dermatological presentations.
- DERLP2.3 Demonstrate the appropriate selection and use of local anaesthetic agents.
- DERLP2.4 Describe best practice use of skin antiseptics.
- DERLP2.5 Describe and perform basic skin surgery, including the excisional biopsy of small skin lesions.
- DERLP2.6 Manage skin wounds through primary and secondary intention healing.
- DERLP2.7 Manage safe and appropriate use of diathermy and cryotherapy.

### 3. Population health and the context of general practice

- DERLP3.1 Describe the relationship between skin disease and the physical environment.
- DERLP3.2 Describe the impact of skin disease in psychological, social and financial terms.
- DERLP3.3 Demonstrate that the promotion and practise of the principles of preventive care is highly relevant to the skin, including sun protection measures and the prevention of occupational dermatoses.
- DERLP3.4 Demonstrate screening for skin cancers according to evidence based guidelines including targeting specific high risk populations.

### 4. Professional and ethical role

- DERLP4.1 Demonstrate that the potential risks and complications of procedures undertaken in the hospital environment are acknowledged when counselling patients for informed consent.
- DERLP4.2 Demonstrate provision of information for skin problems for patients.
- DERLP4.3 Demonstrate up-to-date knowledge about clinical decision making for general practice skin conditions and their management.
- DERLP4.4 Demonstrate the processes involved in informing other treating doctors, especially the patient's GP, of the patient's course, outcome and clinical needs in a timely and accurate way.

## 5. Organisational and legal dimensions

- DERLP5.1 Describe the notification requirements of major diseases and the mechanisms through which notification occurs.
- DERLP5.2 Demonstrate compliance with hospital protocols on infectious disease control. For example managing multiple resistant organisms such as methicillin resistant *Staphylococcus aureus* (MRSA).
- DERLP5.3 Demonstrate accurate and contemporaneous recording of skin symptoms, signs and treatments undertaken.
- DERLP5.4 Describe clear referral pathways for patients with skin symptoms.
- DERLP5.5 Demonstrate unambiguous and appropriate discharge plans for patients.
- DERLP5.6 Describe personal limitations in knowledge and the importance of seeking appropriate advice.
- DERLP5.7 Demonstrate the adoption of a team approach to patient care.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- DERLV1.1 Demonstrate how patients are allowed to communicate their concerns, fears and expectations.
- DERLV1.2 Demonstrate patient engagement about their understanding of their skin condition, including reinforcing helpful beliefs and correcting any troubling misconceptions (eg. 'is my psoriasis contagious?').
- DERLV1.3 Demonstrate how the results of patients' current and past treatments, including any complementary medicines, are recorded and reviewed.
- DERLV1.4 Integrate the negotiation of an effective long term management plan (especially important in the management of chronic illness).
- DERLV1.5 Demonstrate how to reinforce patient understanding of the difference between control and cure.
- DERLV1.6 Confirm patient understanding of the condition and the agreed management plan.

### 2. Applied professional knowledge and skills

- DERLV2.1 Demonstrate how to take an appropriate history and conduct a thorough skin examination.
- DERLV2.2 Effectively use a dermatoscope, where appropriate, for additional help in assessing pigmented and nonpigmented lesions (this may involve specific training).
- DERLV2.3 Demonstrate diagnosis of common general practice dermatological problems.
- DERLV2.4 Demonstrate the ability to critically interpret investigations including biopsy.
- DERLV2.5 Demonstrate the ability to diagnose and manage major dermatological problems, particularly in paediatrics, pregnancy and the aged.
- DERLV2.6 Describe medication side effects that may manifest as skin symptoms, effectively mimicking other dermatological diseases including viral exanthems.
- DERLV2.7 Describe the major disorders of the hair and nails including fungal diseases and local malignancy.
- DERLV2.8 Demonstrate writing prescriptions for useful extemporaneous preparations.
- DERLV2.9 Demonstrate recognition of serious dermatological conditions, including rare conditions and arrange management.
- DERLV2.10 Demonstrate, where appropriate, competency in performing basic procedures such as obtaining skin scrapings, sampling for bacterial microscopy and culture, viral sampling, punch biopsy and formal excisional biopsy.

### 3. Population health and the context of general practice

- DERLV3.1 Describe the financial and time burden of some skin treatments for patients and their families.
- DERLV3.2 Describe how exposure to irritants and allergens at home and in the workplace may precipitate skin disease (eg. eczema, contact dermatitis).
- DERLV3.3 Outline the prevention of skin cancer, including patient discussion of sun protection, and the general practice surveillance of high risk groups including familial forms of dysplastic naevi and melanoma.
- DERLV3.4 Demonstrate prevention education of sun skin damage by participating in community and workplace related education and policy strategies.
- DERLV3.5 Describe how the implications of skin disease outbreaks in the general community demand unique strategies in management beyond treating the individual patient (eg. scabies, lice, impetigo, herpes zoster and meningococcal disease) especially in schools, nursing homes and hospitals.
- DERLV3.6 Describe skin conditions which are notifiable, how they are notified and school/work exclusion periods.

### 4. Professional and ethical role

- DERLV4.1 Outline personal limitations in dermatology skills or knowledge and describe how to be prepared to ask for help.
- DERLV4.2 Demonstrate how to avoid vulnerable anatomical structures during skin surgical procedures (eg. temporal branch of facial nerve).
- DERLV4.3 Demonstrate the important surface landmarks for the facial, accessory and marginal mandibular nerves.
- DERLV4.4 Demonstrate sensitivity to the potential lifelong misery and stigma of some skin conditions, including visible birthmarks, psoriasis, alopecia and acne.

### 5. Organisational and legal dimensions

- DERLV5.1 Demonstrate that a reliable record system is in place for all biopsies, investigations and excisions sent from the practice.
- DERLV5.2 Outline clear practice mechanisms for the transmission of relevant information to patients about their test results.
- DERLV5.3 Demonstrate a clear paper or computer record of the flow of information.
- DERLV5.4 Demonstrate the ability to make contemporaneous, legible and accurate notes.
- DERLV5.5 Describe potential work related compensation issues with respect to skin disease (eg. allergic contact dermatitis).
- DERLV5.6 Where appropriate, demonstrate how patients can access reliable information about skin diseases, which may include printed brochures from recognised authorities.
- DERLV5.7 Demonstrate compliance with practice standards when performing dermatological procedures. For example, infection control standards including sterilisation of instruments.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- DERLC1.1 Describe the personal impact of visible and, possibly, stigmatising skin conditions on a person.
- DERLC1.2 Demonstrate the ability to assess the emotional and financial impact of skin disease.
- DERLC1.3 Describe how mental illness can be associated with, or exacerbated by, skin disease.
- DERLC1.4 Describe the importance of counselling patients who have unrealistic expectations; it is important to be realistic about expectations with regard to timeframes and treatment outcomes (eg. acne treatment).
- DERLC1.5 Describe methods to improve counselling skills for patients with complex management needs (eg. managing acne, psoriasis, eczema and vitiligo).

### 2. Applied professional knowledge and skills

- DERLC2.1 Demonstrate review of ongoing skills and methods to confidently diagnose and manage skin diseases commonly arising within the local practice population and community (eg. a patient audit may provide guidance as to what the common local diseases are).
- DERLC2.2 Describe the long term management of depression in chronic skin disease.
- DERLC2.3 Demonstrate confident and competent use of a dermatoscope.
- DERLC2.4 Demonstrate confident and competent performance of skin procedures.
- DERLC2.5 Describe dermatological treatment complications.
- DERLC2.6 Demonstrate increasing knowledge in skin complications of systemic disease (eg. diabetes, peripheral vascular disease, immunocompromised, obesity).
- DERLC2.7 Describe the psychiatric manifestation of skin disease such as trichotillomania, body dysmorphism, delusions of infestation (parasitophobia).
- DERLC2.8 Demonstrate improvement in ulcer management skills.

### 3. Population health and the context of general practice

- DERLC3.1 Describe the particular skin problems of immunosuppressed patients including organ transplant patients.
- DERLC3.2 Demonstrate ready access to recommended exclusion periods for childhood exanthems.

## 4. Professional and ethical role

- DERLC4.1 Demonstrate regular participation in dermatology updates.
- DERLC4.2 Where appropriate, demonstrate further and higher learning in dermatology, including learning advanced surgical techniques (eg. skin flaps, grafts and complex repairs), advanced diagnostic skills of pigmented lesions, and diploma and masters courses in dermatology.
- DERLC4.3 Demonstrate regular reflection of personal limitations in dermatology and refer when appropriate.
- DERLC4.4 Demonstrate informed consent for all dermatological procedures.

## 5. Organisational and legal dimensions

- DERLC5.1 Demonstrate practice processes for reliable and sterile equipment for all dermatological procedures.
- DERLC5.2 Demonstrate compliance with sterilisation methods and maintain instruments and sterilisation procedures to RACGP *Infection control standards for office based practices*.
- DERLC5.3 Demonstrate the provision of patient space and privacy for disrobing, examination and treatment.
- DERLC5.4 Describe the establishment of links with dermatology and surgical colleagues for ongoing patient dermatologic treatments.
- DERLC5.5 Demonstrate processes for staff training and protocols for tray presentations, equipment, waste disposal, cleaning and sterilisation.
- DERLC5.6 Demonstrate appropriate follow up policies are in place for patient recall, result notification and action required, and that these policies are enacted.
- DERLC5.7 Demonstrate compliance with communicable notification requirements.

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## *Drug and alcohol medicine*

### Contents

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Definition	267
Curriculum in practice	267
Rationale and general practice context	268
Training outcomes of the five domains of general practice	269
Learning objectives across the GP professional life	271
<i>Medical student</i>	271
<i>Prevocational doctor</i>	272
<i>Vocational registrar</i>	274
<i>Continuing professional development</i>	276
References	278

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## Definition

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Drug and alcohol medicine in general practice potentially covers all drug and substance use disorders.

There are significant areas of overlap with mental health, as comorbidity is common among substance users.

Pain management and addiction issues, as well as doctor's health, tobacco and gambling problems, are also part of this field.

## Curriculum in practice

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The following case illustrates how the drug and alcohol medicine curriculum applies to general practice:

- Mandy, 29 years of age, was on a methadone program for 4 years, but was discharged when she kept intermittently using heroin. She has not been receiving regular care for several months. She arrives today late in the afternoon asking to be fitted in as she is feeling very unwell. She is shivering and has a low grade fever with a heart rate of 95 bpm. Her main complaint is abdominal cramps and you note she also has dilated pupils and a runny nose. Although initially polite, she is asking for codeine for the pain and the longer you take to examine her, the more agitated and angry she becomes. She says the pain is so bad that she may as well go and kill herself as her life is worthless anyway. She also says that if you would just help her she is ready to turn her life around.

## Rationale and general practice context

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Australia is a drug-using society. National household surveys demonstrate that alcohol is consumed by the majority of the population and that cannabis is the most commonly used illicit drug.<sup>1</sup>

Two legal drugs – alcohol and tobacco, are the two greatest causes of preventable disease and death in this country. These causes include lung cancer, ischaemic heart disease and chronic obstructive pulmonary disease from tobacco – while alcohol contributes to various cancers, alcoholic liver cirrhosis and road injuries.

### The role of GPs in drug and alcohol medicine

General practitioners are increasingly being asked by government and public health authorities to become more involved in the diagnosis and management of drug and alcohol problems in their patients.

General practitioners need a range of medical and psychological skills when managing drug and alcohol problems, as these substances can affect a wide range of physical and mental functions, which directly impact on successful management.

Many GPs resist taking on this role.<sup>2–4</sup> This may stem from lack of confidence and skills in the area, and a belief that intervention is doomed to failure. Other perceived barriers are lack of time, difficulties in raising the topic during the consultation, and having a negative attitude toward individuals with alcohol and other drug problems. Yet the results of interventions by GPs can be very significant.<sup>5</sup> Brief interventions for alcohol abuse and opiate pharmacotherapies for heroin addiction are two common examples of effective GP initiated treatments, proven by multiple studies in Australia and overseas.

General practice is well positioned to manage substance use disorders and the degree to which a particular GP will manage these conditions will depend on the level of skills they possess.

The maintenance of clear professional roles and boundaries is a key principle in the management of drug and alcohol conditions in the general practice setting. Doctors may also need to treat and support drug-using colleagues and need to be aware of specific related treatment issues. Some drugs used for the treatment of alcohol and drug disorders are governed by strict legislative prescribing requirements, which practitioners need to work within.

Drug and alcohol problems are a major public health burden, and GPs are also in an ideal position to help reduce drug related morbidity and mortality.

The management of drug and alcohol conditions requires a multidisciplinary approach to patient management, often in conjunction with other medical and social service agencies. General practitioners need to know where and when to refer patients, and clinicians working in communities with a high rate of substance use disorders may consider incorporating more specialised skills into their everyday work, and this may involve further training in drug and alcohol medicine as required.

### Related curriculum areas

Refer also to the curriculum statements:

- *Aboriginal and Torres Strait Islander health*
- *Children and young people's health*
- *Doctors health*
- *Men's health*
- *Mental health*
- *Multicultural health*
- *Women's health.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- DRUT1.1 Use nonjudgmental and empathic communication when taking a drug and alcohol history.
- DRUT1.2 Effectively engage a patient who has a substance use disorder.
- DRUT1.3 Communicate effectively and appropriately with significant others (eg. the family of person with a substance use disorder).
- DRUT1.4 Discuss common terms and quantities (eg. standard drinks of alcohol and other common drugs used in our community).
- DRUT1.5 Understand what constitutes harmful alcohol and other drug use.
- DRUT1.6 Understand the reasons people have for using drugs.
- DRUT1.7 Apply harm reduction principles, especially in relation to the medical interview.
- DRUT1.8 Use motivational interviewing skills and assess readiness to change.
- DRUT1.9 Providing objective health information on drugs to the patient, and also to community groups if required.
- DRUT1.10 Develop appropriate boundaries in managing the patient's problems, that take into account medicolegal responsibilities, limits of confidentiality and a respectful, therapeutic relationship.
- DRUT1.11 Be aware of risks of inappropriate behaviour when dealing with patients who are socially stigmatised and who may have boundary problems; they can be needy and manipulative at times.
- DRUT1.12 Develop a long lasting therapeutic relationship for managing the range of chronic medical and behavioural issues in the addiction lifecycle.

## 2. Applied professional knowledge and skills

- DRUT2.1 Take a nonjudgmental medical history and perform physical examination relevant to the presenting drug and alcohol problem.
- DRUT2.2 Intervene early in substance use disorders.
- DRUT2.3 Be familiar with the management of the main drugs of abuse in the Australian community.
- DRUT2.4 Manage adolescent drug problems with affected persons and their parents, especially regarding cannabis, alcohol and psychostimulants.
- DRUT2.5 Safely prescribe medications for dealing with drug withdrawal from alcohol, heroin, cannabis and amphetamines, according to skill level.
- DRUT2.6 Assess and advise on comorbidities including hepatitis B and C, and HIV.
- DRUT2.7 Manage common co-existing psychiatric conditions, including personality disorders and how they interact with substance abuse issues.
- DRUT2.8 Manage drug seeking behaviour.
- DRUT2.9 Apply the principles of management of substance use disorders to addictions (eg. gambling).
- DRUT2.10 Assess patients with chronic pain and opiate dependence.

### 3. Population health and the context of general practice

- DRUT3.1 Identify drug and alcohol conditions in practice patients.
- DRUT3.2 Identify those at high risk of drug and alcohol problems.
- DRUT3.3 Detect and, where appropriate, manage mental illness in all patients with drug and alcohol problems.
- DRUT3.4 Manage drug and alcohol disorders in conjunction with carers, families (including children) and the local community.
- DRUT3.5 Manage drug and alcohol problems in patient subpopulations (eg. people from Aboriginal and Torres Strait Islander backgrounds; people from culturally and linguistically diverse backgrounds; and men, women and young people).
- DRUT3.6 Manage, where appropriate, the treatment of drug dependent colleagues, including issues of medical board involvement.

### 4. Professional and ethical role

- DRUT4.1 Understand and practise appropriate confidentiality, including confidentiality issues with a minor (and breaching this), including mandatory notification if needed.
- DRUT4.2 Display nonjudgmental attitudes when managing drug and alcohol conditions.
- DRUT4.3 Outline common responses in the health professional when caring for patients with mental illness and strategies for self care.
- DRUT4.4 Manage common drug and alcohol presentations, intoxication and withdrawal in a nonjudgmental and safe manner.
- DRUT4.5 Assess patient capacity and competency for making decisions when they are intoxicated.
- DRUT4.6 Maintain appropriate professional boundaries with patients who have drug or alcohol problems.
- DRUT4.7 Maintain professional boundaries and behaviours when managing health professionals with drug dependence.
- DRUT4.8 Where appropriate, participate in peer support activities directed at self care and support for colleagues.
- DRUT4.9 Understand prescribing and reporting requirements for drugs of misuse, including illegal and prescription drugs (including opiates and benzodiazepines).
- DRUT4.10 Regularly update knowledge of drug and alcohol legislation and policies that apply to local jurisdictions.

### 5. Organisational and legal dimensions

- DRUT5.1 Practice confidentiality and consent in the practice setting and the circumstances in which these processes may be modified.
- DRUT5.2 Be familiar with drug and alcohol legislation and policies that apply to local practice context.
- DRUT5.3 Work as part of a multidisciplinary team for drug and alcohol treatment.
- DRUT5.4 Work in conjunction with available local drug and alcohol medical and counselling services (eg. drug withdrawal services, forensic services, local psychiatric services, and drug and alcohol physicians) and demonstrate ability to collaborate with these).

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- DRULM1.1 Demonstrate how to take a drug and alcohol history in a nonjudgmental manner.
- DRULM1.2 Demonstrate how to establish rapport and empathy with patients who present with an alcohol or other drug problem.
- DRULM1.3 Describe an interview style that is empathic and incorporates reflective listening.
- DRULM1.4 Describe common terms and quantities (eg. standard drinks of alcohol and other common drugs used in our community).
- DRULM1.5 Describe and discuss some of the reasons people have for using drugs.
- DRULM1.6 Demonstrate how harm reduction principles can be incorporated into the medical interview when dealing with alcohol and other drug problems.

### 2. Applied professional knowledge and skills

- DRULM2.1 Demonstrate how to take a medical history and perform a physical examination relevant to the presenting drug and alcohol problem.
- DRULM2.2 Demonstrate a nonjudgmental attitude when taking a history and adopting a treatment plan.
- DRULM2.3 Describe the main drugs of abuse in the Australian community.
- DRULM2.4 Outline the main treatments available for common drug and alcohol problems.
- DRULM2.5 Describe the pharmacological and pathophysiological effects of commonly abused drugs.

### 3. Population health and the context of general practice

- DRULM3.1 Consider the possibility of mental illness in all drug and alcohol patients because alcohol, tetrahydrocannabinol, amphetamine, volatile substances and opiate classes are all major contributors to morbidity and mortality.

### 4. Professional and ethical role

- DRULM4.1 Describe how confidentiality issues may relate to personal and family situations.
- DRULM4.2 Display a nonjudgmental approach to drug and alcohol medicine.
- DRULM4.3 Describe issues of the vulnerability of health professionals to becoming drug dependent.
- DRULM4.4 Outline common responses in the health professional when caring for patients with mental illness and discuss strategies for self care.
- DRULM4.5 Describe the professional responsibilities and the legislative requirements of the prescription of drugs, including drugs of dependence, and the potential for misuse.

### 5. Organisational and legal dimensions

- DRULM5.1 Outline the principles of confidentiality and consent in the practice setting and the circumstances in which these processes may be modified.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- DRULP1.1 Demonstrate effective engagement with a patient who has a substance use disorder.
- DRULP1.2 Describe the fine line between acceptance of the patient and indulgence toward the consequences of unacceptable behaviour.
- DRULP1.3 Describe hazardous alcohol and other drug use from the history and examination.
- DRULP1.4 Demonstrate skills in encouraging safer drug use before dependence occurs (eg. an early intervention phase).
- DRULP1.5 Communicate effectively and appropriately with significant others (eg. family of person with substance use disorder).
- DRULP1.6 Demonstrate ability to provide objective health information on drugs to the patient, and also to community groups if required.

### 2. Applied professional knowledge and skills

- DRULP2.1 Demonstrate how to take a medical history and perform a physical examination relevant to the presenting drug and alcohol problem.
- DRULP2.2 Demonstrate a nonjudgmental attitude when taking a history and adopting a treatment plan.
- DRULP2.3 Describe the main drugs of abuse in the Australian community.
- DRULP2.4 Outline the main treatments available for common drug and alcohol problems.
- DRULP2.5 Describe the pharmacological and pathophysiological effects of commonly abused drugs.

### 3. Population health and the context of general practice

- DRULP3.1 Demonstrate the ability to discuss confidentiality issues with the patient and issues regarding doctor responsibility, to both the patient and the community, regarding their drug use.
- DRULP3.2 Identify those at high risk of drug and alcohol problems in the hospital setting and utilise strategies to screen for mental health disorders.
- DRULP3.3 Discuss the diagnosis and management of mental health disorders with the carers and family of patients with a drug and alcohol condition.
- DRULP3.4 Identify sources of support for carers and families of patients with mental illness.

## 4. Professional and ethical role

- DRULP4.1 Demonstrate management of common drug and alcohol presentations, intoxication and withdrawal in a nonjudgmental but safe manner.
- DRULP4.2 Demonstrate ability to assess patient capacity and competency for making decisions when the patient is intoxicated.
- DRULP4.3 Demonstrate maintenance of appropriate professional boundaries with patients who have drug or alcohol problems.
- DRULP4.4 Describe professional responsibilities regarding drugs of dependence.

## 5. Organisational and legal dimensions

- DRULP5.1 Describe the process for referring patients with drug and alcohol conditions in the hospital setting.
- DRULP5.2 Be aware of legislative requirements when treating a drug dependent patient.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- DRULV1.1 Demonstrate development of appropriate boundaries in managing the patient's problems, which take into account medicolegal responsibilities, limits of confidentiality and a respectful therapeutic relationship.
- DRULV1.2 Be aware of risks of inappropriate behaviour when dealing with patients who are socially stigmatised and who may have boundary problems; they can be needy and manipulative at times.
- DRULV1.3 Demonstrate ability to recognise drug seeking behaviour and have strategies to deal with this behaviour in the clinic.
- DRULV1.4 Demonstrate how to negotiate a management plan with the patient that delineates the roles and responsibilities of the patient (and the doctor).

### 2. Applied professional knowledge and skills

- DRULV2.1 Demonstrate ability, where appropriate, to safely prescribe medications for dealing with drug withdrawal from alcohol, heroin, cannabis and amphetamines.
- DRULV2.2 Demonstrate ability to discuss adolescent drug problems with affected persons and their parents, especially regarding cannabis, alcohol and psychostimulants.
- DRULV2.3 Demonstrate ability to assess and advise on comorbidities including hepatitis B and C and HIV.
- DRULV2.4 Describe common co-existing psychiatric conditions, including personality disorders and how they interact with substance abuse issues.
- DRULV2.5 Outline methadone and buprenorphine programs and their roles in managing opiate dependence.
- DRULV2.6 Describe the biopsychosocial consequences of lifestyle disorganisation that may occur as a result of drug use, and demonstrate an ability to conceptualise a plan to deal with this.
- DRULV2.7 Describe how these management principles apply to other addictions, including gambling.

### 3. Population health and the context of general practice

- DRULV3.1 Implement screening for alcohol and drug use in at risk populations.
- DRULV3.2 Describe the drug and alcohol issues of patient subpopulations (eg. people from Aboriginal and Torres Strait Islander backgrounds, people from culturally and linguistically diverse backgrounds, and men, women and young people).
- DRULV3.3 Recognise and address the needs of carers, siblings and children of those with drug use disorders.

## 4. Professional and ethical role

- DRULV4.1 Demonstrate a range of consulting skills, including the ability to refuse unreasonable requests and setting limits for patients.
- DRULV4.2 Demonstrate ability to develop a management plan for patients with drug dependency.
- DRULV4.3 Describe and, where appropriate, demonstrate basic drug and alcohol counselling and describe when presentations require more intensive management in a drug and alcohol unit.
- DRULV4.4 Detail professional and legislative requirements of the community based prescribing of drugs of dependence, including opiates and benzodiazepines.

## 5. Organisational and legal dimensions

- DRULV5.1 Describe state based regulations regarding the prescribing of drugs of dependence and notifications of persons with drug dependence.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- DRULC1.1 Demonstrate motivational interviewing skills and assess readiness to change.
- DRULC1.2 Demonstrate the ability to develop a long lasting therapeutic relationship for managing the range of chronic medical and behavioural issues in the addiction lifecycle.

### 2. Applied professional knowledge and skills

- DRULC2.1 Demonstrate, where appropriate, training and experience in prescribing opiate substitution pharmacotherapy.
- DRULC2.2 Demonstrate the ability to process the assessment of minors who abuse alcohol or other drugs.
- DRULC2.3 Demonstrate competence in assessing patients with chronic pain and opiate dependence.
- DRULC2.4 Review knowledge requirements for drug affected populations within local community and practice populations.

### 3. Population health and the context of general practice

- DRULC3.1 Seek out opportunities for further training in the mental healthcare of patients from diverse backgrounds, according to local need.
- DRULC3.2 Develop skills in assessing and managing the impaired drug dependent doctor.
- DRULC3.3 Demonstrate ability to provide advice and professional support to a colleague affected by substance abuse problems (often done in conjunction with a designated doctor's health program).
- DRULC3.4 Participate in quality assurance activities of the effectiveness of local mental health promotion and disease prevention (eg. clinical audit).

### 4. Professional and ethical role

- DRULC4.1 Demonstrate participation in peer support activities directed at self care and support for colleagues.
- DRULC4.2 Ensure participation in a peer review or support group of practitioners who also deal in this area.
- DRULC4.3 Describe treatment approaches if encountering a drug dependent colleague or supervisor including the duty to involve the medical board if concerned about the wellbeing of the doctor or their patients.
- DRULC4.4 Outline legal issues for managing minors with drug or alcohol problems.
- DRULC4.5 Demonstrate ability to discuss confidentiality issues with a minor and also explain reasons for breaching this, including mandatory notification if needed.
- DRULC4.6 Regularly update knowledge of drug and alcohol legislation and policies that apply to the local practice context.

## 5. Organisational and legal dimensions

- DRULC5.1 Demonstrate the ability to work as part of a multidisciplinary team.
- DRULC5.2 Describe available local support services (eg. drug withdrawal services, forensic services, local psychiatric services, and drug and alcohol physicians) and demonstrate ability to work collaboratively with them.
- DRULC5.3 Detail staff safety practice measures in place for dealing with alcohol and drug affected individuals.

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## *Eye and ear medicine*

### Contents

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Definition	281
Curriculum in practice	281
Rationale and general practice context	282
Training outcomes of the five domains of general practice	284
Learning objectives across the GP professional life	286
<i>Medical student</i>	286
<i>Prevocational doctor</i>	288
<i>Vocational registrar</i>	289
<i>Continuing professional development</i>	291
References	292

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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## Definition

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General practice eye and ear medicine:

- is the assessment and management of acute, subacute and chronic ophthalmic and otorhinolaryngeal conditions that is conducted by general practitioners
- aims to detect and treat diseases early that may threaten the senses of vision and hearing
- promotes preventive activities that will help Australia reduce the burden of avoidable hearing loss and blindness.

## Curriculum in practice

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Typical presentations that illustrate how the eye and ear medicine curriculum applies to general practice include:

- Ewan, aged 29 years, has been having headaches lately and has noticed that his night vision is quite poor and wonders if he might need glasses. His visual acuity is normal, but visual field testing indicates loss of peripheral vision and his retina appears heavily pigmented on fundoscopy. How would you confirm a diagnosis of *Retinitis pigmentosa*? What dietary changes might you recommend while awaiting specialist review? What is the long term prognosis of his eye condition?
- Brodie, aged 24 years, is complaining that he hasn't been able to clear the water out of his right ear for a week, which has been becoming increasingly painful over the past 24 hours. He is a competition surfer and has already tried a range of over-the-counter preparations without success and wonders if his ear problem might be explained by his recent trip to Hawaii. His ear canal is oedematous and completely occluded by greyish slough. You note that he has significant exostoses. What is the likely diagnosis of his ear pain? What are the common pathogens causing his ear pain and how do these differ in tropical regions? What causes exostoses and how are they treated? How is his ear pain best managed currently, and how may recurrences be reduced?

## Rationale and general practice context

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Eye and ear problems are common general practice presentations. While this curriculum refers to 'ear' medicine, this term is used to include the more commonly accepted terms 'ear, nose and throat' medicine.

### Eye problems in Australian general practice

The burden of visual impairment is not distributed uniformly throughout the world. The least developed regions carry the largest share<sup>1</sup> with 87% of blindness occurring in developing countries.<sup>2</sup> Visual impairment is also unequally distributed across age groups, being largely confined to adults 50 years of age and older.<sup>2</sup> About 50 000 Australians are blind.<sup>3</sup> General practice eye consultations account for about 2.3 out of every 100 consultations and about 8% of medical specialist referrals are to an ophthalmologist.<sup>4</sup>

The blindness rate in Indigenous Australian adults is 1.9%, which is 6.2 times higher than in the nonindigenous population. Over the age of 40 years, Aboriginal and Torres Strait Islander people have six times the rate of blindness of other Australians.<sup>5</sup> Low vision occurs in 9.4% of indigenous adults, which is 2.8 times the rate of the general population. Major causes of blindness in indigenous adults include cataract (32% of cases of blindness), optic atrophy (14%), refractive error (14%), diabetic eye disease (9%) and trachoma (9%). Indigenous adults in very remote areas have more cataract and are less likely to wear glasses, but diabetic eye disease, unoperated cataract and poor reading vision are problems across the whole of Australia.<sup>6</sup>

Indigenous children, especially in remote areas, have better vision than their nonindigenous peers. Overall, low vision occurs in 1.4% of indigenous children (age-standardised rate), which is five times less common than in nonindigenous children. Indigenous children in very remote areas have better vision and less refractive error, but still suffer from trachoma.<sup>6</sup>

General practitioners need to take into account their own skill level, the availability of specialised equipment that they are competent to use, the likelihood of patient injury from either the condition or intervention, and the appropriateness of referral before treating sense-threatening conditions.

The ability for a GP to treat eye conditions also depends on the availability of equipment. For example, GPs in emergency departments may have access to slit lamps, but these may be limited access in other clinical settings. Similarly, rural and remote GPs may require a differing skill set to treat a different range of eye problems, depending on availability of resources.

About 9.4% of Australians aged 55 years or older are visually impaired and about 1.2% are blind. Almost 170 000 Australians aged 65 years or over have visual impairment caused by eye disease. Of these, 51 000 people are classified as blind and almost 119 000 people have low vision.<sup>7</sup> There is a strong association between visual impairment and advancing age and vision problems will become increasingly important within the context of an aging population.

Based on studies that have included an eye examination, cataract is the most common eye disease among Australians aged 65 years or older, affecting over 1.2 million people (almost half of that population). This is followed by age related macular degeneration, diabetic retinopathy and glaucoma. A further 398 400 older Australians are estimated to have early age related maculopathy, which usually carries no symptoms, and are therefore at risk of developing age related macular degeneration.<sup>7</sup>

The increasing rate of type 2 diabetes in the Australian population will also contribute to the total burden of eye disease in Australia.<sup>3</sup>

A distribution imbalance is also found with regard to gender throughout the world, with females having a significantly higher risk of having visual impairment than males.<sup>3</sup> Notwithstanding the progress in surgical intervention that has been made in many countries over the past few decades, cataract remains the leading cause of visual impairment in all regions of the world, except in the most developed countries.<sup>1</sup>

In Aboriginal and Torres Strait Islander communities, the major eye conditions remain diabetic retinopathy, cataract, refractive errors and, for some regions, trachoma, trichiasis and trauma.<sup>5</sup>

## Ear problems in Australian general practice

In 2009–2010, ear problems constituted 3.7 out of every 100 general practice consultations.<sup>4</sup> Of the 3.8 per 100 encounters, 1.0 of these encounters were due to acute otitis media/myringitis, and 0.8 due to ear wax problems. In addition, 6.1% of medical specialist referrals were to an ear, nose and throat specialist.<sup>4</sup>

Latest available estimates indicate that about 3.5 million Australians have hearing loss.<sup>8</sup>

The early detection of hearing loss in children is critical for the development of speech and is a critical role for GPs. Around 3.5 of every 1000 children below the age of 14 years have some hearing impairment.<sup>8,9</sup>

The overall prevalence rates of hearing loss in Australian adults are 26.3% for males 15 years and over, 17.1% for females 15 years and over and 21.6% for the adult population. This equates overall to more than 1 in 4 men and more than 1 in 5 Australian adults who have hearing loss.<sup>8,9</sup>

Around 60% of adults with hearing loss are males, which is attributed to greater workplace noise exposure for men than women. Approximately half of hearing impaired people are in the working age population (15–64 years), and 74% of people over the age of 70 years have some hearing loss.<sup>8,9</sup>

The level of ear disease and hearing loss among Aboriginal and Torres Strait Islander people remains higher than the general Australian population, particularly among children and young adults. Ear infection otitis media, particularly in suppurative forms, is associated with hearing impairment, which affects language development and can cause learning difficulties in children. Permanent hearing loss can occur when not adequately treated and followed up. Otitis media can affect indigenous babies within weeks of birth and a high proportion of children will continue to suffer from chronic suppurative otitis media throughout their developmental years.<sup>10</sup>

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2008 reported that 1 in 10 indigenous children aged 4–14 years experienced an ear or hearing problem. Ear/hearing problems were reported by 12% of indigenous people who participated in the 2004–2005 NATSIHS. Complete or partial deafness was reported by 9% of indigenous people living in remote and nonremote areas, but the level of otitis media was higher for indigenous people living in remote areas (4%) than for those living in nonremote areas (2%). After adjusting for differences in the age structures of the two populations, otitis media was about 2.8 times more common for indigenous people than for nonindigenous people.<sup>10</sup>

## Related curriculum areas

Refer also to the curriculum statements:

- *Aboriginal and Torres Strait Islander health*
- *Aged care.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- EAET1.1 Acknowledge the communication needs of patients with hearing and visual disabilities during consultations.
- EAET1.2 Ensure that the treating clinician's diction and volume of speech is suitable for patients with hearing disabilities.
- EAET1.3 Access Auslan interpreters and engage in a three-way communication, or access other appropriate means of communications assistance when consulting with patients with a hearing disability in the absence of a translator.
- EAET1.4 Understand how a deficit in one or more senses may affect a patient's ability to understand medical communications, or their ability to access health services.
- EAET1.5 Use a patient centred, supportive approach and, where able, develop long term relationships with patients with hearing and/or visual disabilities to access effective general practice care.

## 2. Applied professional knowledge and skills

- EAET2.1 Diagnose, manage and monitor acute, sub-acute and chronic eye and ear conditions.
- EAET2.2 Accurately document and monitor changes in visual acuity and the impact of a reduction in visual acuity on a patient's life.
- EAET2.3 Know the indications for, and use of, prescription and over-the-counter medications in the treatment and prevention of common eye and ear conditions. For example, avoid the use of wax softening agents, the use of pH altering drops in chronic otitis externa, and steroid eye drops unless under the care of a specialist ophthalmologist.
- EAET2.4 Incorporate 'red flag' diagnoses that require urgent and immediate specialist advice or treatment to prevent hearing/visual loss or misdiagnosis of potential carcinoma.
- EAET2.5 Understand the increasing use of alternative and complementary medicines and how they may have an adverse impact on vision and hearing.
- EAET2.6 Understand the epidemiology of tumours affecting eyes, ears, nose and throat areas.
- EAET2.7 Understand the relevant anatomy, physiology, pathology and psychology appropriate to the management of common eye and ear conditions.
- EAET2.8 Understand the current best evidence for the management of common eye and ear conditions and the potential harms of pharmacological and nonpharmacological forms of treatment.
- EAET2.9 Take a history for eye and ear medical presentations and document positive and negative findings.
- EAET2.10 Systematically and competently examine the eyes including the appropriate use of an ophthalmoscope, visual acuity testing, visual field testing and manoeuvres for everting the upper lid.
- EAET2.11 Systematically and competently examine the ears including the appropriate use of an auroscope (otoscope) and other equipment, such as tuning forks, in the assessment of hearing, or Valsalva manoeuvre and pneumatoscopy for the detection of ear drum movement.
- EAET2.12 Interpret an audiogram.
- EAET2.13 Manage potentially urgent eye and ear conditions such as glaucoma and epistaxis.
- EAET2.14 Detect and safely remove foreign bodies from the eye, ear, nose or throat and manage any residual corneal ulcer or rust, including appropriate referral.

### 3. Population health and the context of general practice

- EAET3.1 Encourage behavioural changes, such as smoking cessation, for the prevention of age related macular degeneration and orolaryngeal cancers.
- EAET3.2 Understand international and government policies for treatment and prevention of diseases that can have an impact on patients' vision and hearing. Also have knowledge of the increased burden of disease in specific populations to help target appropriate screening and diagnostic strategies.
- EAET3.3 Understand general practice health promotion to help prevent or reduce the loss of function from illness, injury and disability in vision and hearing.
- EAET3.4 Understand the impact on quality of life from hearing and vision disabilities and what services are available to assist patients with such conditions.

### 4. Professional and ethical role

- EAET4.1 Understand the importance of prevention of loss of hearing and vision.
- EAET4.2 Understand the general practitioner's ethical responsibility for advising patients with visual impairment to report to regulatory authorities regarding their fitness to drive a vehicle or fly an aeroplane.
- EAET4.3 Understand and perform the role of appropriate referral to specialist care for acute and sub-acute eye and ear conditions that may threaten vision or hearing.
- EAET4.4 Understand the role of general practice and multidisciplinary care of patients with chronic eye or ear conditions that may not require the intervention of specialist care.

### 5. Organisational and legal dimensions

- EAET5.1 Use patient reminders – including electronic reminders – to facilitate appropriate proactive care, such as recalling patients with diabetes or glaucoma for regular eye checks or referrals to specialist colleagues.
- EAET5.2 Understand the communication skills and practice systems that clinic staff need to enable equitable access to the practice for people with visual or hearing disabilities.
- EAET5.3 Understand the GP's legal responsibility for reporting visual impairment to regulatory authorities regarding fitness to drive a vehicle or fly an aeroplane, as well as workplace safety.
- EAET5.4 Be aware of the services available to patients with visual or hearing disabilities.
- EAET5.5 Be able to record visual acuity and appropriate follow up mechanisms for patients with potentially vision-threatening conditions.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- EAELM1.1 Describe the impact of sensory impairment on effective patient-doctor communication and measures to address the resulting barriers.
- EAELM1.2 Describe the cultural and social barriers to patient-doctor communication with patients with hearing or visual impairment.
- EAELM1.3 Describe the use of appropriate communication techniques to gather additional history from patients, and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- EAELM1.4 Outline the role of Auslan interpreters in consultations for people with hearing impairment.
- EAELM1.5 Outline differences in approaches when examining vision and hearing in children.

### 2. Applied professional knowledge and skills

- EAELM2.1 Describe relevant history and examination skills for high quality management of eye and ear conditions.
- EAELM2.2 Describe the principles of diagnosis, management and monitoring of acute, sub-acute and chronic eye and ear conditions and comorbidities. Describe how these may relate to the course of the disease over time.
- EAELM2.3 Describe the key identifying complaints of patients with urgent vision/hearing threatening conditions (eg. 'red flag' conditions such as flashes and floaters).
- EAELM2.4 Demonstrate a systematic examination of the eye including competent use of an ophthalmoscope, red reflex, visual acuity and visual field testing including the ability to evert an eyelid.
- EAELM2.5 Demonstrate a systematic examination of the ears, nose and throat of children and adults, including competent use of an auroscope/otoscope, and be able to view the tympanic membrane and test for movement by Valsalva or pneumatoscopy.
- EAELM2.6 Describe the function of the bionic ear and its indications for use.

### 3. Population health and the context of general practice

- EAELM3.1 Describe the clinical characteristics of common eye and ear conditions.
- EAELM3.2 Describe appropriate screening procedures required to identify asymptomatic individuals at risk for common eye and ear diseases. Also describe procedures for those who already have chronic eye and ear conditions (secondary prevention).
- EAELM3.3 Describe barriers that have an impact on patients accessing optimal care for chronic eye and ear conditions and practical strategies that can be adopted to overcome these barriers.
- EAELM3.4 Outline the chronic eye and ear problems of specific community groups, for example, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with a developmental disability.
- EAELM3.5 Outline the demographic groups at increased risk of eye, ear, nose and throat cancers. Discuss preventable causes of vision and hearing loss as it relates to the occupational health and safety of workers.

## 4. Professional and ethical role

- EAELM4.1 Describe the role of the GP in a multidisciplinary team in helping to provide optimal care to people with a chronic eye and ear conditions or disability in the primary healthcare setting.
- EAELM4.2 Discuss potential conflicts between the best interests of the patient with a visual disability who still wishes to drive a vehicle, and the safety of the community. Discuss managing conflict when a patient refuses to cease driving or how to report their disability to regulatory authorities.

## 5. Organisational and legal dimensions

- EAELM5.1 Describe the various health and community resources available for the support, prevention, diagnosis and management of vision and hearing disabilities.
- EAELM5.2 Outline the steps involved in notifying a regulatory authority of a patient's unfitness to drive a vehicle when the patient has refused to notify the authority themselves.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- EAELP1.1 Describe how consultation environmental factors such as privacy, background noise and location can affect communication with vision and hearing impaired patients.
- EAELP1.2 Demonstrate the appropriate use of interpreters, families and carers during patient-doctor communication.
- EAELP1.3 Explain and discuss investigations and therapies of common diseases of eyes and ears to the patient, their carers and their family.

### 2. Applied professional knowledge and skills

- EAELP2.1 Demonstrate history and examination skills for eye and ear conditions that are relevant to high quality hospital-based medicine (including the ability to identify Little's area and attempt to control epistaxis).
- EAELP2.2 Demonstrate an ability to interpret results of physical examination findings to formulate a diagnosis when a hearing loss is present (eg. Rinne's/Weber tests).
- EAELP2.3 Demonstrate the ability to cauterise the anterior nose with silver nitrate.
- EAELP2.4 Demonstrate the ability to remove foreign bodies from eyes, ears, nose or throat (tonsillar bed) under direct vision and know when to refer for specialist care.
- EAELP2.5 Investigate and refer appropriately patients with eye and ear conditions.
- EAELP2.6 Discuss the special issues of drug therapy using topical ophthalmic and otological medications including the risks of toxicity.
- EAELP2.7 Be familiar with the use of a slit lamp, where available, and become confident in the ability to judge the depth of an injury to the eye and systematically examine the eye with this apparatus.
- EAELP2.8 Demonstrate the ability to accurately document patient presentations with eye, ear, nose and throat conditions.
- EAELP2.9 Identify red flag diagnoses that require urgent and immediate specialist advice or treatment to prevent hearing/visual loss or misdiagnosis of potential carcinoma.

### 3. Population health and the context of general practice

- EAELP3.1 Review opportunities for the prevention of eye, ear, nose and throat disease especially among high risk subpopulations.

### 4. Professional and ethical role

- EAELP4.1 Demonstrate the ability to seek assistance/supervision when appropriate.
- EAELP4.2 Demonstrate the capacity to work effectively as part of a team in caring for patients with eye and ear conditions.

### 5. Organisational and legal dimensions

- EAELP5.1 Demonstrate effective discharge communications for patients with eye and ear conditions, including planning for continuity of care.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- EAELV1.1 Demonstrate the ability to develop an understanding of the patient's knowledge, attitudes and meaning of their visual or hearing disability in the general practice setting.
- EAELV1.2 Demonstrate the negotiation and documentation of appropriate management plans for patients with chronic eye and ear conditions to access services and secondary/tertiary healthcare.
- EAELV1.3 Demonstrate skills to support patients who do not respond to medical management, or who are waiting for surgical intervention for their eye and ear conditions in the general practice setting.

### 2. Applied professional knowledge and skills

- EAELV2.1 Demonstrate the ability to perform appropriate screening procedures for chronic eye and ear conditions in the general practice setting (eg. visual acuity testing, screening for age related macular degeneration).
- EAELV2.2 Demonstrate the ability to identify the relevant risk factors for the future development of visual and hearing deficits.
- EAELV2.3 Demonstrate negotiation of secondary and tertiary prevention strategies for patients with chronic (or preventable) eye and ear conditions.
- EAELV2.4 Demonstrate the ability to identify and implement practical and pragmatic approaches to managing and referring the care of common eye and ear conditions in the general practice setting.
- EAELV2.5 Demonstrate the comprehensive assessment and management of patients who present with common eye and ear conditions in general practice, including the use of fluorescein for diagnostic purposes.
- EAELV2.6 Identify when to undertake, or refer for slit lamp, examinations for eye conditions such as trauma and glaucoma.
- EAELV2.7 Demonstrate an understanding and a safe approach to the treatment of corneal foreign bodies that present in general practice.
- EAELV2.8 Demonstrate an understanding and a safe approach to the use of ocular cycloplegic and topical anaesthetic medications in general practice.
- EAELV2.9 Demonstrate reference and utilisation of antibiotic guidelines and best practice medicine in the treatment of common eye and ear conditions in general practice.

### 3. Population health and the context of general practice

- EAELV3.1 Outline current government policies that relate to assisting people with eye and ear disabilities in the general practice setting.
- EAELV3.2 Identify barriers that have an impact on patients accessing optimal care for their eye and ear conditions.
- EAELV3.3 Describe the appropriate use of community services and resources for patients with a visual or hearing disability.
- EAELV3.4 Discuss health inequality in relation to common eye and ear conditions and preventable causes of blindness and deafness.

### 4. Professional and ethical role

- EAELV4.1 Demonstrate the provision of support at times of crisis for patients with sudden hearing or visual loss.
- EAELV4.2 Demonstrate the review of technologies that have been demonstrated to improve health outcomes for people with chronic eye and ear conditions.
- EAELV4.3 Evaluate specialist treatment recommended for patients by discussing the benefits and risks of suggested treatment, and ensure that patients are not denied useful treatments.
- EAELV4.4 Demonstrate the ability to act in the patient's best interest when antibiotics are requested inappropriately for childhood otitis media.

### 5. Organisational and legal dimensions

- EAELV5.1 Demonstrate access to and use of readily accessible evidence based guidelines for prereferral treatment and referral of common eye and ear conditions.
- EAELV5.2 Demonstrate access and referral to services available to patients with visual or hearing disabilities.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- EAELC1.1 Demonstrate the ongoing negotiation and documentation of appropriate management plans for patients with chronic eye and ear conditions.
- EAELC1.2 Demonstrate the use of family history information for disease prevention/case finding.

### 2. Applied professional knowledge and skills

- EAELC2.1 Review the knowledge and skills required for effective and efficient healthcare of eye and ear conditions.
- EAELC2.2 Demonstrate the monitoring of competence in assessment and management of common eye and ear conditions.
- EAELC2.3 Maintain up-to-date knowledge of evidence based advances into the care of common and chronic eye and ear conditions (eg. new treatments for age related macular degeneration).
- EAELC2.4 Understand when to cease eye and ear medications.
- EAELC2.5 Be aware of new medications for common eye and ear conditions and changes to indications for use of established medications due to toxicity issues.

### 3. Population health and the context of general practice

- EAELC3.1 Regularly review the role of the GP in population based eye and ear healthcare initiatives (eg. age related macular degeneration, glaucoma and hearing loss).

### 4. Professional and ethical role

- EAELC4.1 Identify own gaps in knowledge and skills in relation to eye and ear conditions.

### 5. Organisational and legal dimensions

- EAELC5.1 Review practice processes to facilitate communication with hospitals and other facilities in relation to referral of patients with eye and ear conditions.
- EAELC5.2 Demonstrate the use of recall systems to ensure patient review and follow up of chronic eye and ear conditions.

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## *Mental health*

### Contents

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Definition	295
Curriculum in practice	296
Rationale and general practice context	297
Training outcomes of the five domains of general practice	299
Learning objectives across the GP professional life	302
<i>Medical student</i>	302
<i>Prevocational doctor</i>	304
<i>Vocational registrar</i>	306
<i>Continuing professional development</i>	308
References	310

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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## Definition

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General practice mental health in Australia covers the assessment, management and ongoing care of the full range of mental health disorders seen in the community. General practice is also increasingly involved in the early intervention and prevention of mental disorders and the optimisation of mental health.<sup>1,2</sup>

While general practitioners commonly see high prevalence disorders such as depression, anxiety, substance abuse and personality disorders, most will also encounter a range of less common mental health problems including psychosis.

In addition to obvious mental illness, GPs also see and manage lesser degrees of mental health conditions and distress as part of the full spectrum of mental health seen in the community.

A mental disorder is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.<sup>3</sup>

Mental disorders differ in type and severity and some major mental disorders are significant public health issues. These include depression, anxiety, substance use disorders, psychosis and dementia.

Mental disorders are diagnosed by standardised criteria such as those contained in the Diagnostic and Statistical Manual of Mental Disorders<sup>4</sup> and the International Statistical Classification of Diseases and Related Health Problems (10th revision).<sup>5</sup> The term mental illness is synonymous with mental disorder.

A mental health problem also interferes with a person's cognitive, emotional or social abilities, although usually to a lesser extent than a mental disorder. Mental health problems are more common mental complaints and include mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into a mental disorder. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration.

Comorbid mental health conditions are defined as mental health problems that present in people with another condition. Patients may present with other complaints. For example, they may present with chronic medical conditions such as diabetes, a disability or a substance use disorder for which their mental health problem is a comorbidity. People with mental illness have all of the conditions that people without mental health problems have, and so comorbidity is a common general practice presentation. For these patients, the mental health disorder can complicate the management of their other conditions, which needs to be understood and dealt with by the GP.

Available evidence demonstrates that people with mental illness still struggle on a daily basis to access appropriate healthcare, or be treated with respect or dignity when they do enter our healthcare systems.<sup>6</sup> Patients whose primary problem is a mental health disorder also deserve the full range of care, including preventive services, offered in general practice.

## Curriculum in practice

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The following case illustrates how the mental health curriculum applies to general practice:

- Lachlan, 33 years of age, left school early to work as an apprentice in the hospitality sector. He slowly worked toward opening his own restaurant, and by the age of 28 years he achieved this. A talented chef, he had a number of signature dishes featured in the local media and appeared on track to become the region's most popular chef. Lachlan's private life was less rosy. His occupation meant he was working the opposite hours to most of his peers and he slipped into a pattern of sleeping until lunchtime. He commenced work then did not finish until around 2.00 am. Lachlan rarely cooked for himself and tended to eat leftovers or takeaway food. He had been in a relationship with a married patron of the restaurant, but it had ended 6 months before his visit to you. Lachlan's social life was reduced to drinking with his employees after the daily clean-up. Recently he had been arrested for driving under the influence after crashing his car into a fence post. Although his presenting symptoms are fatigue related, he is open about feeling depressed and reports that his life is lacking enjoyment. How do you assess Lachlan's mental state and develop a management plan?

## Rationale and general practice context

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Mental health problems and mental disorders are estimated to affect almost half (45%) of Australians aged 16–85 years at some stage during their lifetime with about one in five (20% or 3.2 million) Australians affected during a 12 month period.<sup>7</sup> In 2008–2009, there were an estimated 13.2 million mental health related general practice encounters.<sup>8</sup>

The burden of disease due to mental disorders is 13% of the total burden of disease in Australia – third in importance after heart disease and cancer.<sup>9</sup> Depression was the tenth most frequent problem<sup>10</sup> managed in 1998–1999 and increased to the fourth most common condition requiring treatment in 2005–2006.<sup>11</sup>

Intentional self harm (including suicide) accounted for 36% of injury related deaths in Australia in 2010 and is a major form of death for people with mental disorders. In Australia, the rate of youth suicide peaked in the 1990s, but is now decreasing. However, after transport accidents, intentional self harm remains the leading cause of death for young people in the 15–24 years age group, accounting for 20% of deaths.<sup>12</sup>

People with mental illness have an elevated risk of preventable natural and unnatural death<sup>13</sup> with psychiatric outpatients being twice as likely to die from diseases such as ischaemic heart disease, which has often gone undetected.<sup>14</sup> Despite a steady decline in cardiovascular mortality for most Australians, people with mental illness have received little or no benefit from this progress.<sup>15,16</sup>

Clinical depression also predicts increased mortality,<sup>17</sup> with comorbid clinical depression and coronary heart disease being especially associated with increased mortality.<sup>18</sup> Many other chronic disorders have been found to be associated with increased depressive morbidity.<sup>19</sup>

Health related quality of life measures suggest the effects of depression on the patient's quality of life are comparable to that of arthritis, diabetes and hypertension, and that depression and chronic illness can interact to amplify these effects.<sup>20</sup> Managing depression as a chronic disease has been shown to improve emotional and physical functioning reflecting the reality of high rates of symptom recurrence and sustained functional impairment.<sup>21</sup>

Special mental health conditions (including effects of discrimination) affect people from diverse backgrounds including issues of gender differences, cultural and linguistic diversity, poverty and issues of sexuality including sexual preference.

### The role of general practitioners in mental health

Mental health work is multidisciplinary, for which GPs are often the first point-of-contact for patients experiencing mental health problems. This includes patients who do not disclose their mental health problems. In addition, GPs are reported as the most common providers of mental health services.<sup>8</sup>

General practitioners require skills to be able to:

- perform a behavioural, emotional and cognitive assessment within the context of a patient's physical findings. This includes a background chronic and current acute problems, with knowledge of their current personal and social circumstances, as well as past experiences
- identify early warning signs
- provide appropriate care
- provide continuity of care – a key factor in the successful treatment of people with mental illness effectively utilise and participate in a multidisciplinary approach to care.

Successful general practice management of mental problems requires skills in chronic disease management<sup>22</sup> and willingness to work in formal liaison with other mental health providers<sup>23</sup> to enhance patient outcomes.

Stigma is a key mental health issue for GPs. Many patients will be reluctant to disclose their mental health issues because they regard these problems as stigmatising and prefer not to discuss them.

Often the GP may be the first health professional to identify a mental health problem in someone who is presenting with a somatic complaint and has been reluctant to discuss mental health issues.

Managing such patients, including appropriate referral, may take time and effort for the GP. General practice patients require competence in instituting initial management, which may require using telephone advice from local mental health services, or national GP psychiatric liaison help lines such as GP Psych Support.<sup>24</sup> If accessing appropriate local mental health services is difficult, the GP may be required to both institute and continue management of mental health disorders.

Many psychological disorders in general practice are self limiting physical illnesses and the GP's role in these situations is to explain, ease distress and act to speed recovery if possible.<sup>25</sup> This requires background knowledge of normal and adaptive psychological reactions to life stressors, commencing from undergraduate education and updated over a GP's lifetime. Patients prefer to be assessed for mental health problems by their GP, rather than a mental health specialist.

Patient improvement in depression has been linked to the strength of the therapeutic relationship<sup>26</sup> and general practice continuity of care may be an advantage where a previous patient-doctor relationship may have been well established already. There is also continuity between communication styles in everyday general practice consultations and communication in consultations with patients presenting emotional problems and psychotherapeutic communication.<sup>25</sup>

Comorbidity of mental health conditions with drug and alcohol problems is another common general practice presentation. The majority of patients with serious drug and alcohol problems also have another mental health disorder and visa versa, which complicates the management of both sets of disorders.

General practice factors that can inhibit a patient from presenting emotional problems in a consultation include poor GP interview behaviours, perceived lack of time, and believing that the GP can do nothing to help.<sup>27</sup>

The GP needs to learn time management skills to assist in managing patients presenting with mental health disorders who are often complex, involving considerable time and effort. Establishing the necessary rapport for effective patient management in these conditions also takes time.

General practitioners may have difficulty accessing appropriate local mental health services, particularly in rural and regional areas. They may be required to both institute and continue management of mental health disorders in such areas, whether or not they have a particular interest in mental health.

The use of multidisciplinary teams in mental health services creates communication challenges between the general practice and mental health services participating in case discussion and care planning. Establishing effective communication and better links between GPs and mental health services facilitates mutual patient care.

The current trend for GPs to be leaders of primary health teams in their own practices will require teams that deal with mental health problems. The GP will need skills to lead such teams, including appropriate communication and the delegation of responsibility.

General practitioners with more experience in managing mental problems and with relevant postgraduate qualifications have been shown to cope better with difficult mental health problems, including patients without medically explained symptoms, somatisation and hypochondria.

## Related curriculum areas

Refer also to the curriculum statements:

- *Aboriginal and Torres Strait Islander health*
- *Aged care*
- *Children and young people's health*
- *Disability*
- *Drug and alcohol medicine*
- *Philosophy and foundation of general practice*
- *Men's health*
- *Multicultural health*
- *Multidisciplinary care*
- *Women's health.*

## Training outcomes of the five domains of general practice

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### Communication skills and the patient-doctor relationship

- MHET1.1 Demonstrate appropriate respect and concern for patients with mental illness and their families and carers.
- MHET1.2 Establish rapport and appropriate patient-doctor relationship boundaries.
- MHET1.3 Identify relevant belief systems and cultural issues.
- MHET1.4 Manage emotionally charged encounters.
- MHET1.5 Manage the emotional impact of mental illness on the patient and carers within a multidisciplinary healthcare team.
- MHET1.6 Manage the stigma associated with mental health and facilitate disclosure of patients' mental health issues.
- MHET1.7 Acknowledge the dignity of patients with mental health problems and respect their attitudes, values and beliefs.
- MHET1.8 Use different counselling approaches, support methods, and appropriate referral agencies (for example for bereavement, interpersonal stress management and angry/frightened patients).

### 2. Applied professional knowledge and skills

- MHET2.1 Perform mental health assessments including developing mental health plans and ongoing review of patients with mental health problems.
- MHET2.2 Understand that GPs who have difficulty in accessing appropriate local mental health services may be required to both institute and continue management of mental health disorders, especially in rural and remote areas.
- MHET2.3 Recognise and assess mental health problems in the early stages of illness.
- MHET2.4 Understand the normal and adaptive psychological reactions to life's stressors.
- MHET2.5 Take a mental health history that emphasises the patient's strengths and enhances self esteem.
- MHET2.6 Perform a behavioural, emotional and cognitive assessment within the context of a patient's physical findings, including background chronic and current acute problems, with knowledge of their current personal and social circumstances and past experiences.
- MHET2.7 Manage the comorbidity of mental and physical illness or problems.
- MHET2.8 Differentiate a patient's reaction to normal life stresses from overt mental illness.
- MHET2.9 Identify the indicators people at risk of a mental health problem, including an understanding of the importance of early intervention and continuity of care.
- MHET2.10 Help patients to manage normal life events to enhance coping skills and prevent secondary morbidity.
- MHET2.11 Understand the principles of psychosocial education, cognitive behaviour therapy and family therapy.
- MHET2.12 Understand the principles of handling a mental health crisis.
- MHET2.13 Initiate appropriate counselling including the use of focused psychological strategies while identifying their own limitations.
- MHET2.14 Coordinate the care of mental health patients at a level that is appropriate to the context in which they are working.

- MHET2.15 Use appropriate psychotherapeutic agents.
- MHET2.16 Understand the principles of detoxification and withdrawal.

### 3. Population health and the context of general practice

- MHET3.1 Recognise the importance of detecting and assessing mental health problems in the early stages of illness.
- MHET3.2 Know the risk factors and prevalence of mental illness to enable the early identification and management of mental health problems, including screening and active case finding.
- MHET3.3 Use mental health promotion and education to assist patient populations in preventing and managing their mental health problems in accordance with recommendations of national mental health policies.
- MHET3.4 Acknowledge comorbidity of mental health with drug and alcohol use.
- MHET3.5 Acknowledge and address stigma affecting people affected by mental illness.
- MHET3.6 Acknowledge cultural and linguistic issues and special issues for patient subpopulations, eg. different age groups, gender and minority groups.
- MHET3.7 Recognise and address the needs of carers, siblings and the children of those with mental health problems, eg. issues relating to dysfunctional families, stepfamilies, scapegoating, human immunodeficiency virus (HIV) and psychogeriatric patients.
- MHET3.8 Recognise signs of mental illness in colleagues and providing debriefing, support and appropriate referral.

### 4. Professional and ethical role

- MHET4.1 Understand the roles of all multidisciplinary team members to facilitate care planning and ongoing review of patients with mental health disorders.
- MHET4.2 Understand that mental healthcare includes relationships not only with the patient, but also with their carers, family and significant social supports.
- MHET4.3 Work effectively as part of a multidisciplinary team in conjunction with mental health services.
- MHET4.4 Be able to lead teams using appropriate communication and the delegation of responsibility when working in a multidisciplinary team or in shared care arrangements.
- MHET4.5 Recognise the need for confidentiality and its maintenance in the management of patients with mental health issues, especially due to the stigma associated with mental health and the potential for discrimination.
- MHET4.6 Maintain self care strategies and avenues for debriefing when caring for mental health patients.
- MHET4.7 Acknowledge and manage patient-doctor professional boundaries, particularly in the areas of time management and in transference issues.
- MHET4.8 Undertake ongoing education in mental health that may include the need to participate in ongoing peer support programs.
- MHET4.9 Understand a doctor's responsibility to recognise signs of mental illness in themselves and their colleagues, and to accept and provide appropriate support and referral.
- MHET4.10 Recognise and take into account a doctor's own strengths, vulnerabilities, personal values, gender and cultural issues, attitudes and beliefs in relation to mental health management.

## 5. Organisational and legal dimensions

- MHET5.1 Ensure that appropriate practice procedures and processes are in place for monitoring and ongoing patient review in mental health.
- MHET5.2 Use time management skills to assist in managing mental health disorders, which are often complex.
- MHET5.3 Work effectively with available community and hospital resources in the care of patients with mental health problems.
- MHET5.4 Be able to apply current mental health legislation and procedures appropriately for the involuntary admission of patients, or for patients not competent to make informed decisions, eg. Power of Attorney, Mental Health Act, Guardianship and Administration Board Act, Freedom of Information Act.
- MHET5.5 Know policy guidelines on accessibility, confidentiality and continuity of care.
- MHET5.6 Understand requirements for reporting to the relevant registration board and medical indemnity requirements regarding impaired colleagues.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- MHELM1.1 Demonstrate appropriate respect and concern for patients with mental health concerns and their families and carers.
- MHELM1.2 Demonstrate how to establish and maintain appropriate boundaries in the patient-doctor relationship.
- MHELM1.3 Demonstrate strategies for managing the emotionally charged encounter, eg. breaking bad news, dealing with grief.
- MHELM1.4 Discuss the emotional impact of illness on the patient with other members of the healthcare team.

### 2. Applied professional knowledge and skills

- MHELM2.1 Describe the integration of psychological and neurobiological knowledge in performing a behavioural, emotional and cognitive assessment within the context of a patient's physical findings (including background chronic and current acute problems) with knowledge of their current personal and social circumstances and past experiences.
- MHELM2.2 Briefly describe the personality development and personality types.
- MHELM2.3 Describe the basics of pathological, pharmacological and hormonal effects on mental functioning.
- MHELM2.4 Demonstrate familiarity with psychiatric diagnostic frameworks, eg. International Classification of Diseases, Diagnostic and Statistical manual and describe common psychiatric syndromes and disorders.
- MHELM2.5 Demonstrate familiarity with basic tools to aid mental health assessment (eg. K10).
- MHELM2.6 Outline the stages of normal psychological development from birth to old age.
- MHELM2.7 Briefly outline the principles of sociology and the influences of socioeconomic status, race, gender, and culture on the expectations about, acceptance of, and access to medical treatment.
- MHELM2.8 Describe the various schools of psychotherapy and their evidence base.
- MHELM2.9 Outline the general principles of treatment of the common psychiatric disorders and syndromes.
- MHELM2.10 Identify key members of the mental healthcare team.
- MHELM2.11 Understand the principles of classical and operant conditioning.
- MHELM2.12 Describe the common risk factors, physical and mental health impact and principles of treatment for substance use disorders.
- MHELM2.13 Apply evidence based medicine in mental healthcare.

### 3. Population health and the context of general practice

- MHELM3.1 Describe the common risk factors for high prevalence mental health conditions.
- MHELM3.2 Outline the main effects mental illness may have on carers, siblings and children of the mentally ill.
- MHELM3.3 Describe the roles of members of the mental healthcare team including psychologists, psychiatrists, social workers, GPs, nurses and carers.
- MHELM3.4 Outline the principles of preventive mental healthcare for all population subgroups.
- MHELM3.5 Understand the range of mental health disorders and problems in the community setting dealt with by GPs.

### 4. Professional and ethical role

- MHELM4.1 Demonstrate how to establish and maintain appropriate boundaries in the patient-doctor relationship with appropriate use of mentors to assist.
- MHELM4.2 Seek to understand your own reactions to confronting clinical situations relating to the delivery of mental healthcare and be ready to seek counsel from teachers, or other clinical mentors to optimise your own mental health.
- MHELM4.3 Outline the role of the GP in relation to population mental health issues.
- MHELM4.4 Outline common responses of health professionals when caring for patients with mental illness and strategies for self care.

### 5. Organisational and legal dimensions

- MHELM5.1 Describe the conditions under which a patient may be admitted involuntarily in the local context.
- MHELM5.2 Outline the principles of confidentiality and consent, and the circumstances in which these processes may be modified.
- MHELM5.3 Outline common responses in the health professional when caring for patients with mental illness, and strategies for self care.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- MHELP1.1 Demonstrate effective communication with patients with mental health concerns and their families and carers.
- MHELP1.2 Demonstrate appropriate respect and concern for patients with mental health concerns and their families and carers.
- MHELP1.3 Discuss strategies for managing the emotionally charged encounter, eg. breaking bad news, dealing with grief.
- MHELP1.4 Demonstrate how to establish and maintain appropriate boundaries in the patient-doctor relationship.
- MHELP1.5 Integrate effective communication into consultations with the patient who is emotionally distressed and their families.

### 2. Applied professional knowledge and skills

- MHELP2.1 Integrate psychological and neurobiological knowledge when performing a behavioural, emotional and cognitive assessment within the context of a patient's physical findings (including background chronic and current acute problems) with knowledge of their current personal and social circumstances and past experiences.
- MHELP2.2 Identify the common mental health comorbidities that occur in the context of physical illness or disability.
- MHELP2.3 Demonstrate ability to take a psychiatric history, perform a mental status and risk assessment in the hospital setting.
- MHELP2.4 Utilise the most recent psychiatric diagnostic frameworks, eg. International Classification of Diseases and the Diagnostic and Statistical Manual.
- MHELP2.5 Describe common psychiatric presentations.
- MHELP2.6 Utilise basic tools to aid mental health assessment, eg. mini mental state examination.
- MHELP2.7 Perform a focused mental health assessment.
- MHELP2.8 Describe the impact of acute and chronic physical illness and disability on the mental health of patients in the hospital setting.
- MHELP2.9 Describe resources available for patients with mental illness that take into account cultural and gender context.
- MHELP2.10 Be familiar with the common pharmacological and psychological treatments available for patients with common mental health disorders.
- MHELP2.11 Discuss the emotional impact of illness on the patient with other members of the healthcare team.
- MHELP2.12 Describe the common pharmacological and psychological treatments to patients.
- MHELP2.13 Outline the roles and functions of key members of the mental healthcare team in the hospital and community setting.

- MHELP2.14 Describe the use of psychological techniques in the management of patients with physical illness, eg. motivational interviewing for lifestyle change or medication concordance.
- MHELP2.15 Identify support services for patients with substance use disorders, and negotiate initial engagement with these services.

### 3. Population health and the context of general practice

- MHELP3.1 Identify those at high risk of mental illness in the hospital setting and utilise strategies to screen for mental health disorders.
- MHELP3.2 Discuss the diagnosis and management of mental health disorders with the carers and family of patients with mental illness.
- MHELP3.3 Identify sources of support for carers and family of patients with mental illness.

### 4. Professional and ethical role

- MHELP4.1 Describe the role of primary, secondary and tertiary care in the management of patients with mental illness.
- MHELP4.2 Demonstrate inclusion of the patient's GP in the management of patients with mental illness in the hospital setting under the guidance of the team leader.
- MHELP4.3 Describe your own reactions to confronting clinical mental healthcare situations and role of counsel from teachers, or other clinical mentors for self care.
- MHELP4.4 Outline self care strategies and avenues for debriefing when caring for mental health patients.
- MHELP4.5 Demonstrate communication with other members of the health care team utilising written, verbal and computer mediated communication, including communication with the patient's GP upon patient admission and discharge from an acute or outpatient care under the guidance of the team leader.

### 5. Organisational and legal dimensions

- MHELP5.1 Outline procedures for the certification of involuntary patients.
- MHELP5.2 Discuss the principles of confidentiality in the context of team care.

# Learning objectives across the GP professional life —

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- MHELV1.1 Integrate effective communication with patients with mental health concerns and their families and carers in the primary care setting.
- MHELV1.2 Demonstrate appropriate respect and concern for patients with mental health concerns and their families and carers in the primary care setting.
- MHELV1.3 Integrate strategies for managing the emotionally charged encounter (eg. breaking bad news, dealing with grief) into the primary care setting.
- MHELV1.4 Establish rapport with patients with mental health concerns and their families and carers.
- MHELV1.5 Identify the impact of the belief systems and cultural norms of both doctor and patient during communication.
- MHELV1.6 Establish partnerships of care incorporating patients, carers, healthcare professionals and support staff utilising written, verbal and computer mediated communication.

### 2. Applied professional knowledge and skills

- MHELV2.1 Describe the epidemiology and aetiology of common mental health conditions and the complexities of comorbidity.
- MHELV2.2 Demonstrate skills in psychiatric history taking, mental status assessment and risk assessment in the general practice setting.
- MHELV2.3 Detect and differentiate the common mental health disorders in general practice.
- MHELV2.4 Demonstrate appropriate use of psychometric instruments to aid assessment.
- MHELV2.5 Demonstrate how to differentiate a patient's reaction to normal life stresses from overt mental illness.
- MHELV2.6 Demonstrate the inclusion of mental health assessment in undifferentiated clinical presentations.
- MHELV2.7 Assess the functional impact of mental health disorders on a patient.
- MHELV2.8 Negotiate a mental health plan with patients, carers and health professionals considering patient and carer preferences, concerns and resources.
- MHELV2.9 Communicate the evidence basis for common treatments to patients and carers.
- MHELV2.10 Describe appropriate patient and carer education methods and materials.
- MHELV2.11 Describe local mental healthcare providers and systems including nongovernment organisations, eg. self help groups.
- MHELV2.12 Describe available pharmacological and psychological therapies and utilise these therapies in an evidence based way.
- MHELV2.13 Outline the principal of detoxification and withdrawal.
- MHELV2.14 Deliver focused psychological strategies, where appropriate as defined by the governmental mental health Initiatives.
- MHELV2.15 Demonstrate the appropriate prescription of psychoactive medication using an evidence based approach.

- MHELV2.16 Work collaboratively with members of the local healthcare network.
- MHELV2.17 Describe the need for systematic monitoring of the effectiveness of a mental health plan.
- MHELV2.18 Manage comorbidity of mental and physical illness.
- MHELV2.19 Describe how to engage patients in self monitoring to identify recurrence.
- MHELV2.20 Assist patients and carers to develop a personal relapse prevention plan.
- MHELV2.21 Recognise signs of mental illness in colleagues and provide debriefing, support and appropriate referral.

### 3. Population health and the context of general practice

- MHELV3.1 Implement evidenced based screening for mental health problems in at risk populations.
- MHELV3.2 Describe the mental health special requirements of patient subpopulations, eg. people from Aboriginal and Torres Strait Islander backgrounds, people from culturally and linguistically diverse backgrounds, men, women and young people.
- MHELV3.3 Demonstrate the effective physical and mental healthcare management in patients with mental health problems.
- MHELV3.4 Recognise and address the needs of carers, siblings and children of those with mental health problems.

### 4. Professional and ethical role

- MHELV4.1 Describe the apportioning of clinical time in a manner considered appropriate in local context by patients and peers.
- MHELV4.2 Describe the role of the general practice in reconciling competing patient demands in mental health.
- MHELV4.3 Utilise appropriate billing systems and government initiatives to fund efficient and effective mental healthcare.
- MHELV4.4 Describe the role of the GP in relation to mental health.
- MHELV4.5 Describe a role for general practice in advocacy for systemic change.
- MHELV4.6 Outline self care strategies and avenues for debriefing when caring for mental health patients.

### 5. Organisational and legal dimensions

- MHELV5.1 Outline the current mental health legislation and procedures for the certification of involuntary patients.
- MHELV5.2 Discuss policy guidelines on accessibility, confidentiality and continuity of care.
- MHELV5.3 Detail the requirements for reporting to the relevant registration board and medical indemnity requirements regarding impaired colleagues.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- MHELC1.1 Review communication skills and work to improve these with high quality experience based skills training.
- MHELC1.2 Consider seeking out advanced communication skills training.

### 2. Applied professional knowledge and skills

- MHELC2.1 Develop expertise in mental healthcare in specialised areas according to local need, eg. in paediatrics, young people, aged care, drug and alcohol and correctional services.
- MHELC2.2 Participate in continuing professional development activities that enhance diagnostic skills of atypical presentations and less common mental health disorders.
- MHELC2.3 Where appropriate, or as a special interest, develop skills in supervision and mentoring of general practice registrars undertaking mental health training.
- MHELC2.4 Seek skills in the delivery of focused psychological strategies including reattribution for patients who frequently somatise their mental health problems, and may be at a risk of over investigation and inappropriate medical treatments.
- MHELC2.5 Regularly update knowledge on the emerging evidence base for treatments of mental health disorders via continuing professional development opportunities.
- MHELC2.6 Demonstrate ongoing training in new advances in medications (including appropriate use, actions and side effects profiles).
- MHELC2.7 Develop skills in working with local mental healthcare providers and non-government organisations to deliver optimal mental healthcare.
- MHELC2.8 Where appropriate or as a special interest, develop skills in the delivery of a range of evidence based treatments (eg. interpersonal therapy, cognitive and behavioural therapy).
- MHELC2.9 Where appropriate, or as a special interest, participate in ongoing continuing professional development in the area of drug and alcohol management (eg. clinical attachments).
- MHELC2.10 Develop skills in enhancing the effectiveness of relapse prevention in mental healthcare.

### 3. Population health and the context of general practice

- MHELC3.1 Seek out opportunities for further training in the mental healthcare of patients from diverse backgrounds, according to local need.
- MHELC3.2 Regularly participate in quality assurance activities of the effectiveness of local mental health promotion and disease prevention (eg. clinical audit).

## 4. Professional and ethical role

- MHELC4.1 Mentor and supervise general practice registrars in time management and reconciling competing demands.
- MHELC4.2 Where appropriate, or as a special interest, participate in ongoing peer support to optimise understanding of issues arising from the patient-doctor relationship (eg. Balint groups or supervision).
- MHELC4.3 Participate in peer support activities directed at self care and support for colleagues.
- MHELC4.4 Where appropriate, or as a special interest, seek out opportunities to participate actively as an advocate for the role of general practice in mental healthcare (eg. curriculum development, advisory committees, research).
- MHELC4.5 Regularly participate in interdisciplinary quality assurance and education activities according to local need.

## 5. Organisational and legal dimensions

- MHELC5.1 Regularly update knowledge of mental health legislation and policies as it applies to local practice context.
- MHELC5.2 Participate in the promotion of improvements to financially viable systems to enable best care for people with mental health problems and disorders.

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## *Musculoskeletal medicine*

### Contents

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Definition	315
Curriculum in practice	315
Rationale and general practice context	316
Training outcomes of the five domains of general practice	318
Learning objectives across the GP professional life	320
<i>Medical student</i>	320
<i>Prevocational doctor</i>	322
<i>Vocational registrar</i>	324
<i>Continuing professional development</i>	327
References	329

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Curriculum for Australian General Practice 2011**

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## Definition

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Musculoskeletal medicine embodies all medical disciplines that deal with the diagnosis of acute and chronic conditions affecting the musculoskeletal system in adults and children, including the psychosocial impact of these conditions.

Musculoskeletal conditions may result from a wide range of processes including injury, inflammation, infection, metabolic or endocrinological conditions and the normal aging process.

Musculoskeletal medicine incorporates aspects of orthopaedics, rheumatology, rehabilitation medicine and pain medicine.

Musculoskeletal, or orthopaedic medicine, includes common ailments such as whiplash, back and buttock pain where findings on radiological investigation do not often correlate strongly with the clinical presentation, requiring a detailed clinical examination to assess biomechanical dysfunction and to interpret referred pain patterns. This subspecialty provides professional links between medical practitioners and allied health disciplines such as physiotherapy, occupational therapy, osteopathy, chiropractic, myotherapy and exercise physiology.

Musculoskeletal conditions cause a significant pain burden in the community that often involve complex psychological processes. Psychological conditions can result in somatic pain and many people with chronic pain have comorbid psychological diagnoses.

The successful management of musculoskeletal conditions requires a holistic, patient centred approach.

## Curriculum in practice

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The following cases illustrate how the musculoskeletal medicine curriculum applies to general practice:

- Jack, 70 years of age, has recently retired. He now plays golf several times a week. He has developed pain in his right shoulder over the past couple of weeks that is progressively worsening and now wakes him from sleep if he rolls onto that side. He is otherwise well, with mild hypertension and a history of low back pain. On examination he has an element of pain consistent with rotator cuff injury and tendonitis. He wants to know his treatment options, but also how this could have been avoided.
- Louise, 32 years of age, presents with 1 week of swollen and painful finger joints, as well as feeling tired. On examination, she has swelling of her proximal interphalangeal joints on both hands, which are tender. She also looks tired.

## Rationale and general practice context

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Musculoskeletal conditions are responsible for a major burden in the Australian health system, affecting around 31% of the population – more than 6 million Australians. Globally, one in four people report chronic musculoskeletal impairments in both less and more developed countries. These conditions consume enormous healthcare and social resources, representing almost 25% of the total cost of illness in western countries.<sup>1</sup> In 2008, the World Health Organization estimated that musculoskeletal diseases were the fifth largest cause of global years of life lost due to disability, accounting for more than 5% of the total.<sup>2</sup>

Musculoskeletal conditions are the most common cause of severe long term pain and physical disability<sup>3</sup> and are major causes for work limitation and early retirement.<sup>3</sup> Back pain, joint disorders (osteoarthritis and rheumatoid arthritis) and osteoporosis make the greatest contribution to this burden and have been targeted as a national health priority area with a national action plan by the Department of Health and Ageing.

A common misconception is that chronic musculoskeletal conditions are inevitable and an unavoidable consequence of aging. In reality, the burden of arthritis and musculoskeletal conditions can be reduced through intervention at various points along the disease continuum including prevention, early diagnosis, prompt initiation of treatment, ongoing management and timely access to joint replacement.<sup>4</sup> In addition, children and young people can be affected by chronic musculoskeletal conditions, such as juvenile rheumatoid arthritis. These misconceptions may lead to missed opportunities to address potentially modifiable risk factors, prevent or slow progression, improve management and optimise health related quality of life.<sup>5</sup>

### Musculoskeletal conditions and Australian general practice

General practice plays an important role within the Australian healthcare system in the prevention, early detection and management of chronic disease, including musculoskeletal disease.

Musculoskeletal conditions accounted for 15.4% of general practice encounters in 2009–2010, and were the third most common reason for presentation.<sup>6</sup> Back complaints accounted for 3.1% of reasons for presentation, followed by knee (1.4%), foot/toe (1.1%), shoulder (1.1%), neck (1.0%), leg (0.8%) and other (0.7%).<sup>6</sup> The nature of general practice provides the opportunity for early screening for chronic disease and enables preventable risk factors to be addressed early.

For example, the early diagnosis and management of rheumatoid arthritis greatly reduces long term joint damage and improves outcomes. General practitioners need to be able to diagnose rheumatoid arthritis as early as possible in order to optimise outcomes for patients.<sup>5</sup>

Up to 18% of women and 10% of men aged over 65 years have symptomatic osteoarthritis characterised by joint pain and mobility impairment. Comprehensive assessment leading to an early diagnosis and appropriate intervention can significantly relieve signs and symptoms and expedite joint replacement when required.<sup>7</sup>

Half of all women and a third of all men will suffer minimal trauma fractures secondary to osteoporosis.<sup>8</sup> Early identification and management can prevent many of the longer term disastrous consequences.<sup>8</sup>

The impact of musculoskeletal conditions on quality of life is large, not only in terms of activity limitation and functional restrictions, but also from pain and self perceived state of health. For example, about 10% of people with rheumatoid arthritis reported very high levels of psychological distress.<sup>4</sup> Independent living of a large proportion of people with arthritis and musculoskeletal conditions is compromised and many experience psychosocial changes in their lives such as a change in marital status and employment as a result of their disease or condition.<sup>4</sup>

Through both direct intervention and promotion of self management strategies, the GP clearly has a critical role in the management of these and other musculoskeletal conditions, which continue to increase in incidence and prevalence with our aging population and poor health, secondary to obesity and life style choices.

**Note:** this curriculum statement is consistent with the musculoskeletal medicine educational requirements for Australian GPs according to the Australian National Musculoskeletal Core Competencies<sup>9</sup> and the global curriculum recommendations of the International Bone and Joint Decade Undergraduate Curriculum Group.<sup>3</sup> In addition, this statement is also consistent with the musculoskeletal medicine syllabus of the Australasian Faculty of Musculoskeletal Medicine<sup>10</sup> and the evidenced based *Clinical guidelines for musculoskeletal diseases* of The Royal Australian College of General Practitioners.<sup>11</sup>

## Related curriculum areas

Refer also to the curriculum statements:

- *Integrative medicine*
- *Occupational health and safety*
- *Pain management*
- *Sports medicine*
- *Chronic conditions.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- MSKT1.1** Understand the particular importance of common presentations of pain and how the subjective nature of pain requires that the consultation process initially focuses on taking a good pain history. This includes, where appropriate, history taking from the patient's family members, carers, employers.
- MSKT1.2** Efficiently elicit information while simultaneously employing empathy and patience with patients suffering pain.
- MSKT1.3** Understand the need for careful detailed history taking for presentations of vague or non-specific symptoms common in many musculoskeletal general practice presentations.
- MSKT1.4** Use empathy and motivational interviewing skills to help develop a sound therapeutic partnership with the patient, especially as many conditions require long term treatment.
- MSKT1.5** Communicate where appropriate, and in conjunction with the patient, with the patient's family members, carers, employers and others to promote successful disease monitoring and plan rehabilitation options.
- MSKT1.6** Communicate prevention strategies for pain and dysfunction in common musculoskeletal conditions including benefits and risks of lifestyle factors, physical activity, minimising immobility and avoiding of specific risks.
- MSKT1.7** Use appropriate communication skills for patient education and enhancing self management which are key strategies in effective musculoskeletal general practice care.

## 2. Applied professional knowledge and skills

- MSKT2.1** Know the wide range of musculoskeletal conditions is necessary to successfully manage the diversity of musculoskeletal general practice presentations including assessment techniques, differential diagnosis and disease management. This includes a thorough knowledge of the basic sciences, normal versus abnormal function and a biopsychosocial/multidisciplinary approach to care.
- MSKT2.2** Understand that as pain is the most common symptom of musculoskeletal conditions treatment outcomes are directed at pain reduction, as well as improving function, modifying disease progression and decreasing the risk of future loss of function or recurrence.
- MSKT2.3** Understand the role of patient safety concerns in the treatment of musculoskeletal conditions treatments, such as the overriding principle of 'first do no harm' because while evidence based medicine is critical to managing musculoskeletal conditions, many treatments in this area continue to be based on experience and empiricism.

### 3. Population health and the context of general practice

- MSKT3.1 Understand that the early diagnosis and management of common general practice musculoskeletal presentations not only improves patient quality and quantity of life, but is a major public health intervention to reduce community morbidity and mortality, and their economic impact.
- MSKT3.2 Know the epidemiology and patterns of musculoskeletal diseases to help the early diagnosis of musculoskeletal conditions.
- MSKT3.3 Identify risk factors for musculoskeletal disease and disease prevention to help reduce musculoskeletal related morbidity and mortality.
- MSKT3.4 Understand how the chronicity and morbidity associated with many musculoskeletal conditions requires work, family and social factors to be considered in their general practice management.

### 4. Professional and ethical role

- MSKT4.1 Understand how musculoskeletal conditions often require the GP to work with other health professionals within a multidisciplinary team including, where appropriate, employers. This is done while maintaining appropriate professional boundaries (see curriculum statement *Occupational medicine*).
- MSKT4.2 Understand that patients with musculoskeletal pain problems often seek help from alternative and allied health practitioners using treatment paradigms that may differ widely from the traditional medical model.
- MSKT4.3 Develop strategies for working with patients using nonmedical paradigms to maintain patient-doctor relationships while maintaining an awareness of potential for harm as a result of other therapies.

### 5. Organisational and legal dimensions

- MSKT5.1 Understand that many general practice musculoskeletal consultations involve legal aspects such as work related, motor vehicle, and assault injury cases and have a basic knowledge of the relevant prevailing legal system within each jurisdiction.
- MSKT5.2 Know how to make assessments and pronouncements on musculoskeletal injuries that affect the patient and their legal outcomes.
- MSKT5.3 Be able to distinguish between registered and nonregistered musculoskeletal therapists.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- MSKLM1.1 Describe the characteristic natural history of common musculoskeletal conditions and how this knowledge, when combined with good history taking, helps to confirm or exclude many conditions.
- MSKLM1.2 Demonstrate the ability to take a sound history of the pain including nature, intensity, location, duration, onset, offset, concomitant factors, aggravating factors, relieving factors, radiation, frequency, sleep, irritability, response to previous treatment.
- MSKLM1.3 Demonstrate the use of pain charts, visual analogue scales and functional assessment charts to interpret and complete a patient's history.
- MSKLM1.4 Demonstrate an ability to empathetically take a history from a patient suffering pain.
- MSKLM1.5 Describe the role of effective communication in the principles and practice of patient education and self management.

### 2. Applied professional knowledge and skills

- MSKLM2.1 Outline basic sciences necessary for dealing with the musculoskeletal system including anatomy, physiology, pathology and embryology.
- MSKLM2.2 Understand the basics of pain physiology and the multiple inputs affecting the modulation of pain.
- MSKLM2.3 Demonstrate an ability to take a basic history/examination to allow the formulation of a differential diagnosis.
- MSKLM2.4 Outline investigations that may be useful in solving diagnostic and management problems in practice.
- MSKLM2.5 Describe the factors involved in deciding whether imaging and related investigations are indicated or not.
- MSKLM2.6 Describe the adverse effects of inappropriate imaging and investigations in musculoskeletal conditions.
- MSKLM2.7 Describe why an understanding of and the ability to identify serious diseases early, including red flag emergencies, is central to effective musculoskeletal care.
- MSKLM2.8 Describe the common musculoskeletal conditions that occur in Australians and their prognosis.
- MSKLM2.9 Outline the affect of chronic pain on sleep.
- MSKLM2.10 Describe the principles of the biopsychosocial health model.
- MSKLM2.11 Outline the role of analgesics in clinical management of musculoskeletal conditions.
- MSKLM2.12 Outline management of common musculoskeletal conditions and their efficacies.
- MSKLM2.13 Outline the principles involved in evaluating the efficacy of treatments for musculoskeletal conditions, including alternative or complementary therapies.
- MSKLM2.14 Describe the concept of chronic disease self management.

### 3. Population health and the context of general practice

- MSKLM3.1 Describe the diversity of conditions encompassed by musculoskeletal conditions.
- MSKLM3.2 Describe how the different disease processes and natural history of the various musculoskeletal conditions affect prevention and treatment priorities, eg. the role of early treatment in inflammatory arthritis.
- MSKLM3.3 Demonstrate the ability to identify modifiable risk factors for musculoskeletal conditions.
- MSKLM3.4 Describe the potential impact of musculoskeletal conditions on children, family, work and other social roles.
- MSKLM3.5 Describe how musculoskeletal conditions result in substantial costs to the community.
- MSKLM3.6 Outline the importance of patient education and chronic disease self management in musculoskeletal conditions.

### 4. Professional and ethical role

- MSKLM4.1 Outline the reasons why many musculoskeletal conditions require a multidisciplinary approach to management.

### 5. Organisational and legal dimensions

- MSKLM5.1 Describe how access to services can affect patient outcomes.
- MSKLM5.2 Demonstrate the ability to organise the medical consultation into its various components of history, examination, differential diagnosis, investigations, diagnosis and management.
- MSKLM5.3 Outline the jurisdictional legislative requirements for medical practitioners in dealing with work related health and insurance issues, and for motor traffic injury cases.
- MSKLM5.4 Describe the difference between the terms: impairment, disability, and handicap and their legal implications.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- MSKLP1.1 Demonstrate the ability to take a full history including presenting musculoskeletal complaint, history of the presenting complaint and to make a provisional diagnosis in the acute hospital setting.
- MSKLP1.2 Demonstrate the ability to identify and interpret pain behaviours such as limping, moaning, grimacing, other body language and use of aids in a patient suffering from musculoskeletal pain.
- MSKLP1.3 Demonstrate empathetic communication with patients in the hospital setting.
- MSKLP1.4 Demonstrate the pursuit of opportunities to interview relatives of patients who present to hospital with a musculoskeletal pain problem to enhance history taking and information gathering.
- MSKLP1.5 Demonstrate an ability to reassure patients in pain and provide lucid explanations as to diagnosis, physiology and prognosis to patients with musculoskeletal problems.
- MSKLP1.6 Demonstrate the ability to counsel patients about musculoskeletal conditions.
- MSKLP1.7 Demonstrate the importance of an ongoing relationship of trust in chronic healthcare.

### 2. Applied professional knowledge and skills

- MSKLP2.1 Demonstrate the ability to perform a complete and thorough musculoskeletal history and examination.
- MSKLP2.2 Demonstrate how to identify psychosocial stressors of musculoskeletal conditions ('yellow flags') and incorporate them into pertinent management strategies.
- MSKLP2.3 Describe the investigations available to rule in, or out, emergency and urgent ('red flag') diagnoses and their relative advantages/disadvantages.
- MSKLP2.4 Outline basic clinical biomechanics.
- MSKLP2.5 Demonstrate an ability to differentiate between pain types, eg. acute, chronic, somatic (nociceptive), somatic referred, neuropathic, visceral and nonorganic.
- MSKLP2.6 Outline the concept of non-organic pain.
- MSKLP2.7 Demonstrate the ability to formulate a management plan for musculoskeletal conditions, including appropriate referral and incorporating psychosocial issues.
- MSKLP2.8 Demonstrate a thorough knowledge of medications commonly used in the management of musculoskeletal conditions.
- MSKLP2.9 Demonstrate the ability to search for and access evidence based resources for musculoskeletal conditions.

### 3. Population health and the context of general practice

- MSKLP3.1 Describe the patterns of differing conditions across different populations, for example, age groups (children and adults) or gender.
- MSKLP3.2 Describe methods involved in primary, secondary and tertiary prevention of musculoskeletal disorders.
- MSKLP3.3 Describe the different disease processes and natural history associated with arthritis and related disorders, osteoporosis, other diseases of the musculoskeletal system and connective tissue and musculoskeletal injuries.
- MSKLP3.4 Describe the implications of different disease natural histories for primary and secondary prevention and prevention/reduction of morbidity.
- MSKLP3.5 Describe the socioeconomic and geographical inequities in access to services for musculoskeletal conditions.
- MSKLP3.6 Describe how chronic disease self management can affect the health of people with musculoskeletal conditions.
- MSKLP3.7 Demonstrate the ability to intervene with patients to address modifiable risk factors.
- MSKLP3.8 Describe the economic impact of the musculoskeletal conditions including those conditions that contribute most to these costs.

### 4. Professional and ethical role

- MSKLP4.1 Demonstrate the ability to work in a multidisciplinary team to manage musculoskeletal conditions.
- MSKLP4.2 Describe the specific roles of different allied health professionals in the prevention and management of musculoskeletal conditions.
- MSKLP4.3 Outline the co-ordination of care across disciplines in more complex musculoskeletal complaints including compiling return to work/activity plans.
- MSKLP4.4 Identify patients who require advocacy and guidance to enable them to access necessary services and social and economic supports to manage their condition.
- MSKLP4.5 Demonstrate the ability to support patient self determination, including patients using alternative and complementary therapies.
- MSKLP4.6 Demonstrate the ability to counsel patients about potential adverse effects of unproven remedies while maintaining professional boundaries.

### 5. Organisational and legal dimensions

- MSKLP5.1 Describe the work related aspects of musculoskeletal conditions and the implications for certifying sickness and work capacity.
- MSKLP5.2 Outline the basic legislative requirements for sickness certification and fitness for duties.
- MSKLP5.3 Describe how to formulate a basic rehabilitation program for injured workers.
- MSKLP5.4 Describe the need for gaining informed consent from patients prior to interventional procedures.
- MSKLP5.5 Demonstrate the ability to write competent referrals and communications to participate in multidisciplinary care.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- MSKLV1.1 Describe the psychological influences and consequences of acute and chronic pain.
- MSKLV1.2 Describe the psychological influences and consequences of loss of function, or the burden of being at higher risk of deteriorating pain or function.
- MSKLV1.3 Demonstrate the ability to distinguish between patients' needs and wants with regards to their pain management.
- MSKLV1.4 Describe the role of the placebo response in pain management and the importance of the therapeutic relationship between doctor and patient in achieving the placebo response.
- MSKLV1.5 Demonstrate the skills and attitudes required for effective whole person care.
- MSKLV1.6 Describe how clinician attitudes, beliefs and feelings may affect pain management.
- MSKLV1.7 Describe information sources that may assist the patient with a musculoskeletal condition to better manage their condition.
- MSKLV1.8 Demonstrate a high level of use of explanation of pain mechanisms and natural history using analogy, metaphors and patient centred communication to teach the patient self care.
- MSKLV1.9 Demonstrate a high level of skills in motivational interviewing techniques to assist patients in dealing with persisting musculoskeletal problems.
- MSKLV1.10 Describe the role of cognitive behavioural therapy to assist patients in rehabilitation.
- MSKLV1.11 Describe the effect of a clinician's communication styles and body language when communicating with patients.

### 2. Applied professional knowledge and skills

- MSKLV2.1 Demonstrate how to take a comprehensive history, including identification of urgent and emergency conditions ('red flags') and important psychosocial stressors on musculoskeletal conditions ('yellow flags').
- MSKLV2.2 Demonstrate how to take a comprehensive pain history.
- MSKLV2.3 Demonstrate how to measure disability and impairment.
- MSKLV2.4 Demonstrate thorough examination of the musculoskeletal system including identifying dysfunctions, special physical tests and their interpretation.
- MSKLV2.5 Demonstrate a high level of knowledge of specific musculoskeletal conditions across different populations.
- MSKLV2.6 Describe the optimal sequence of ordering investigations to aid management decisions to demonstrate the ability to justify the necessity for each investigation and interpret the result.
- MSKLV2.7 Describe the prevalence of radiological abnormalities in a symptomatic and symptomatic populations.
- MSKLV2.8 Recognise radiological findings of emergency and urgent ('red flag') conditions.

- MSKLV2.9 Demonstrate the ability to detail a comprehensive management plan for musculoskeletal complaints that may involve more than one healthcare provider. It may incorporate, where appropriate, the role of medications, patient education and reassurance, therapeutic exercise, rehabilitation, manual therapy, intraarticular injections and other regional techniques, psychological interventions, and surgery.
- MSKLV2.10 Justify the use of interventions through risk/benefit analyses.
- MSKLV2.11 Demonstrate an awareness of the levels of evidence for musculoskeletal management strategies.
- MSKLV2.12 Identify and acquire musculoskeletal procedural skill competency levels appropriate for the required service provision level, eg. if performing joint injections ensure skill competency level has been acquired.
- MSKLV2.13 Demonstrate the ability to monitor musculoskeletal disease status and medication use in terms of compliance and toxicity, including in the presence of comorbid illnesses such as cardiovascular disease.

### 3. Population health and the context of general practice

- MSKLV3.1 Outline the differences between pain perception, suffering and pain behaviour in those from different cultures and backgrounds.
- MSKLV3.2 Describe the differences in the spectrum of musculoskeletal conditions seen in general practice and other healthcare settings for different age groups, and understand the implications of this for patient care.
- MSKLV3.3 Describe the prevalence of various musculoskeletal conditions in the clinician's own local community and practice.
- MSKLV3.4 Identify chronic disease management programs, how to access them in the local community and how to collaborate with these programs.
- MSKLV3.5 Identify, where possible, how to reduce the specific impacts of a patient's musculoskeletal condition on family, work, school and other social roles.
- MSKLV3.6 Outline the relative cost effectiveness of diagnostic and management options for musculoskeletal conditions.

### 4. Professional and ethical role

- MSKLV4.1 Identify when there is a need for a multidisciplinary approach for musculoskeletal medical care.
- MSKLV4.2 Identify specific medical specialists and allied health professionals who will be required for the prevention and management of musculoskeletal conditions in specific patients.
- MSKLV4.3 Demonstrate the ability to coordinate care across disciplines in more complex musculoskeletal complaints, including compiling return to work/activity plans.
- MSKLV4.4 Demonstrate the ability to advocate for patients and to guide them to enable them to access necessary services and social and economic supports to manage their condition.

## 5. Organisational and legal dimensions

- MSKLV5.1 Describe the importance of systematic approaches to prevention and management of musculoskeletal conditions.
- MSKLV5.2 Describe the formulation and facilitation of a detailed rehabilitation program for injured workers.
- MSKLV5.3 Describe how best to use government policy initiatives to maximise the care of patients with musculoskeletal conditions.
- MSKLV5.4 Demonstrate reliable ways of recording and following patient outcomes.
- MSKLV5.5 Demonstrate a basic ability to assess impairment, disability, and handicap in injured workers for occupational/legal purposes.
- MSKLV5.6 Describe the legislative and legal requirements in report writing, and also providing evidence in court as an expert witnesses.
- MSKLV5.7 Demonstrate the ability to coordinate care involving multidisciplinary teams and to organise case conferences where required.
- MSKLV5.8 Describe patient confidentiality requirements and appropriate communication with stakeholders to whom the patient has given the doctor permission to disclose – for example, insurance companies and rehabilitation providers.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- MSKLC1.1 Undertake regular analysis of communication skills in relation to musculoskeletal medicine, which may include tools such as reviewing interview techniques with peers or mentors, or patient feedback tools within the clinical setting.

### 2. Applied professional knowledge and skills

- MSKLC2.1 Demonstrate review of ongoing skills and methods to confidently diagnose and manage musculoskeletal diseases commonly arising within the local practice population and community (for example, a patient audit may provide guidance as to what the common local diseases are).
- MSKLC2.2 Demonstrate knowledge of complementary and alternative therapies used in the management of musculoskeletal conditions.
- MSKLC2.3 Describe the effects of nutrition, fitness and exercise on health in the musculoskeletal system.
- MSKLC2.4 Demonstrate the ability to critically evaluate the literature concerning musculoskeletal medicine.
- MSKLC2.5 Describe the principles of conducting musculoskeletal research in primary practice.
- MSKLC2.6 Demonstrate a commitment to ongoing medical education including, where relevant, specific manual and injection techniques that are useful to control pain and improve function.
- MSKLC2.7 Describe advances in knowledge regarding the prevention of musculoskeletal conditions.
- MSKLC2.8 Maintain musculoskeletal procedural skill competency levels appropriate for the required service provision level, for example if performing joint injections, ensure skill competency level are maintained.

### 3. Population health and the context of general practice

- MSKLC3.1 Demonstrate skills to differentiate between evidence based healthcare and non-evidence based healthcare for musculoskeletal conditions, and be able to accurately communicate this to individuals and groups.
- MSKLC3.2 Identify the unmet needs of the clinician's community for the best management of musculoskeletal conditions.
- MSKLC3.3 Demonstrate skills to modify diagnosis, treatment and chronic disease self management in line with developments in evidence based healthcare.
- MSKLC3.4 Identify and use new resources, particularly those based on reliable evidence, for the prevention and management of musculoskeletal conditions as they become available.

## 4. Professional and ethical role

- MSKLC4.1 Demonstrate the ongoing coordination of multidisciplinary care for patients with musculoskeletal disorders as required.
- MSKLC4.2 Describe the GP's role in assisting or empowering their community to gain access to necessary services/treatments/diagnostic resources to manage musculoskeletal conditions.
- MSKLC4.3 Consider and undertake further course or specialist training in musculoskeletal medicine as appropriate for the skill level required.

## 5. Organisational and legal dimensions

- MSKLC5.1 Demonstrate an ability to regularly audit patient outcomes.
- MSKLC5.2 Demonstrate a basic familiarity with Australian Medical Association Guides to the assessment of impairment, disability and handicap in injured workers.
- MSKLC5.3 Describe how to formulate a full rehabilitation program for injured workers.
- MSKLC5.4 Self review of written medicolegal reports to ensure that they aid the legal process in making timely determinations.

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## *Occupational medicine*

### **Contents**

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Definition	333
Curriculum in practice	333
Rationale and general practice context	334
Training outcomes of the five domains of general practice	335
Learning objectives across the GP professional life	337
<i>Medical student</i>	337
<i>Prevocational doctor</i>	338
<i>Vocational registrar</i>	339
<i>Continuing professional development</i>	340
References	341

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## Definition

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Occupational medicine deals with all aspects of the relationship between the work environment and the health of workers,<sup>1</sup> with the aim of improving health and minimising injuries in the workplace.

General practitioners can bring medical expertise to the human interface of the workplace to help provide improved outcomes in both physical and mental health, assist in the reduction and elimination of preventable accident or injury, and reduce and prevent the potential for negative health impacts from the work environment.

## Curriculum in practice

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Typical cases that illustrate how the occupational medicine curriculum applies to general practice include:

- Ricko's hand was wrapped and elevated but his clothes were drenched in blood and sawdust when he presented to your practice. His face remained pale as his workmate described the accident with a bandsaw at the mill where they worked. Ricko was passing a slab of timber through the saw when he was momentarily distracted and ran his hand up the middle with the wood. Without removing the dressing, X-ray examination confirmed a massive injury to his hand with splintered metacarpals and one missing digit. Ricko is transferred to hospital for specialised hand surgery. Some months later he has completed rehabilitation and is keen to return to work but you are uncertain as to the risk of future wound contamination and the risk of further injury. How might a workplace assessment help?
- Alison has been working in the office of a construction company for several months but was recently relocated closer to the worksite. The new office has an exterior door that connects to the site, with the result that considerable dust enters the building and becomes airborne every time she moves a file. Alison's previously stable asthma has become problematic, with erratic peak flow readings. She has needed to use prednisone on several occasions and has needed several days off work. She wonders if this change in her previously stable asthma is due to the dust exposure in her work environment. Alison has also become highly anxious about job security as the company has commenced downsizing. She is concerned that further days off work might jeopardise her employment contract, which is up for review. What role does the workplace play in exacerbating Alison's respiratory and anxiety symptoms and what options are available to manage the situation with her employer?
- Col presents to the local hospital, greatly agitated, having drenched one arm in pesticide. He has brought the label from the pesticide container with him and you see it is an organophosphate. Like many small owner-operators Col had not been using protective equipment, including mask or gloves, while mixing the chemicals. What emergency measures should be taken by staff and what treatment should be administered? What is Col's prognosis?

## Rationale and general practice context

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In Australia in 2009–2010, 1.6% of general practice encounters were work related,<sup>1</sup> with men more likely to present with work related conditions than women.<sup>2</sup> Nearly all of these patients (96%) were aged 15–64 years with half being in the 25–44 years age group.<sup>2</sup>

General practice occupational medicine activities traditionally include accident prevention, injury management, workers' compensation and pre-employment and occupational health medical examinations. In reality, the scope of occupational medicine in the general practice setting goes beyond these tasks.

General practitioners are well situated to give advice on the most diverse of working environments, from a sterile laboratory in a large company to a farmer on the family farm to potential health outcomes of a manufacturing process. They may not only treat, but anticipate, biomechanical sequelae for operators of equipment, often specifically engineered for a particular process with little regard for the impact on workers' health.

The list of potential occupational health and safety (OH&S) roles for the GP include: fitness to operate equipment such as forklifts or tractors; the effects of drugs, either legal or illegal, in the workplace; first aid including cardiopulmonary resuscitation; information seminars; safety drills; and interpretation of safety data information. Some GPs may be involved in monitoring the health effects of short and long term exposure to noxious substances, and all GPs have a role in the treatment of work related stress and implementing strategies to reduce its incidence.

The workplace is one of the few places, outside schools, where people gather on a regular basis, often in large numbers. This provides an ideal opportunity for health promotion and wellness programs. General practitioners are ideally placed to play a pivotal role in brokering positive health outcomes and preventing the spiral into chronic incapacity with its attendant consequences.

General practitioners are in a unique position to act as moderators between patient and employer to ensure the best possible outcomes for both parties. Specific occupational health skills are needed to maximise the special opportunities that GPs have to effect good health outcomes. Poorly managed work related conditions can cause great suffering, not only for the patient and the employer, but also the patient's family as a result of unemployment.

General practitioners are also often employers and need to be aware of their own OH&S obligations toward their employees.

### Related curriculum areas

Refer also to the curriculum statements:

- *Doctors' health* for the relationship between the treating doctor's health and workplace safety
- *Practice management* for areas of occupational health and safety within the general practice workplace
- *Population health and public health* for health promotion programs that may be intended in the workplace setting
- *Philosophy and foundation of general practice* for issues of confidentiality
- *Multicultural health* for successful cross cultural communication including the correct use of translators.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- OCCT1.1 Integrate knowledge of the specific confidentiality and privacy demands of work related injuries into patient management.
- OCCT1.2 Communicate effectively with the patient and all parties involved in injury management while recognising that the primary responsibility is the patient's health.
- OCCT1.3 Communicate appropriately with the patient's employer, workplace, insurance agencies, work rehabilitation providers and a wide range of health professionals, being mindful of the potential for communication conflicts between these stakeholders and the patient.
- OCCT1.4 Facilitate good outcomes for both the patient and the employer.
- OCCT1.5 Utilise appropriate translation services for patients from non-English speaking backgrounds, consistent with the communication requirements listed in the *Multicultural health* curriculum statement to ensure cultural competence when managing work related injury and illness.

## 2. Applied professional knowledge and skills

- OCCT2.1 Understand the role of accident prevention and proactive risk management in the workplace to prevent physical and mental work related illness and injury.
- OCCT2.2 Manage medical aspects of work related illness and injury.
- OCCT2.3 Manage the expectations of all work related injury management stakeholders.
- OCCT2.4 Participate in relevant work injury related administrative processes with work insurance authorities.
- OCCT2.5 Perform pre-employment medicals and where relevant, onsite assessments.
- OCCT2.6 Use evidence based medicine for the early intervention and active management of work related illness and injury.
- OCCT2.7 Be aware of the realities of the patient's workplace, the available resources and the prevailing culture when making patient management plans.
- OCCT2.8 Understand how the differences between industries and workplaces in worker safety, availability of human resources and management skills impact on negotiating best patient outcomes, especially when the patient has few or no portable skills.

## 3. Population health and the context of general practice

- OCCT3.1 Administer workplace health programs (eg. relevant immunisations) and other strategies for the reduction of potential injury or substance exposure, or general health promotion and lifestyle programs.
- OCCT3.2 Influence workplace cultures, where appropriate, to adopt practices consistent with long term beneficial health worker outcomes that may have significant flow on benefits to the wider community.
- OCCT3.3 Understand how work related health disability has a wider impact beyond the worker to the patient's family and supports, which can result in hardship and suffering, especially in people from disadvantaged socioeconomic and educational backgrounds, who are particularly vulnerable to the negative impact of unemployment, financial hardship and family breakdown.

## 4. Professional and ethical role

- OCCT4.1 Understand how working within a multidisciplinary team, including with work insurance authorities, is critical to the successful management of work related injuries.
- OCCT4.2 Know the medical and legal issues in relation to medical certification.
- OCCT4.3 Act as an advocate for patients, where appropriate, to ensure a successful outcome, especially for those from disadvantaged socioeconomic and educational backgrounds.
- OCCT4.4 Balance any competing priorities of workers and employment as required, including maintaining appropriate professional conduct by delineating the role of medical management to work toward the best outcome for all parties.
- OCCT4.5 Understand the obligations of management and the role of statutory inspectors in workplace safety breaches.
- OCCT4.6 Know how a doctor's health may impair work related performance (see *Doctors' health* curriculum statement).

## 5. Organisational and legal dimensions

- OCCT5.1 Know the relevant OH&S legislative requirements of employers and employees and work insurance agencies, and workers' compensation and industrial relations issues that impact on patient health.
- OCCT5.2 Manage the potentially large amounts of information generated during the management of work related injuries from a range of sources to ensure that health risks to the patient are minimised from communication errors, including the maintenance of patient privacy.
- OCCT5.3 Have expertise in safety matters, workers negotiations, unions and documenting workplace safety within the clinician's own workplace. This includes the clinician's own workplace health and safety legislative requirements.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- OCCLM1.1 Demonstrate asking for the patient's occupation when taking a history.
- OCCLM1.2 Describe the negotiating skills needed in OH&S.
- OCCLM1.3 Describe the implications of work related stress, including on personal relationships and communication.

### 2. Applied professional knowledge and skills

- OCCLM2.1 Discuss the possible effects of illness on occupation or the relationship between an occupation and illness.
- OCCLM2.2 Describe the basic role of biomechanics in workplace injuries and the role of ergonomics in the workplace.
- OCCLM2.3 Outline the relationship of long and short term occupational exposure limits to noxious substances.
- OCCLM2.4 Describe management issues in work related stress.
- OCCLM2.5 Examine and describe workers' compensation insurance certificates, eg. Workcover certificates.

### 3. Population health and the context of general practice

- OCCLM3.1 Understand the need for occupation related immunisation.
- OCCLM3.2 Examine and describe the place of health promotion programs in the workplace.
- OCCLM3.3 Describe the role of occupation related infection control measures in illness prevention.
- OCCLM3.4 Describe the need and requirements for first aid training in the workplace.

### 4. Professional and ethical role

- OCCLM4.1 Outline the roles of the GP and the occupational health doctor.
- OCCLM4.2 Describe the roles and importance of professionals in the multidisciplinary work related health team, including occupational therapists and rehabilitation providers.

### 5. Organisational and legal dimensions

- OCCLM5.1 Describe OH&S legislative requirements.
- OCCLM5.2 Demonstrate awareness of regulatory standards to assess safety and ability to drive, including commercial and dangerous goods vehicles.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- OCCLP1.1 Describe informed consent issues with respect to the patient and their employer.
- OCCLP1.2 Demonstrate the use of basic negotiating skills when aiming for best outcomes for both patient and employer.
- OCCLP1.3 Describe the impact of work related injuries on the patient's family, especially in serious work related injuries in the emergency situation.

### 2. Applied professional knowledge and skills

- OCCLP2.1 Write work injury related certificates, especially first certificates for work related emergency presentations, minor trauma and musculoskeletal diagnoses.
- OCCLP2.2 Outline early management options for work related emergency presentations, minor trauma and musculoskeletal diagnoses.

### 3. Population health and the context of general practice

- OCCLP3.1 Describe how to promote risk awareness in the workplace.
- OCCLP3.2 Demonstrate appropriate occupation related immunisation.
- OCCLP3.3 Demonstrate how to identify potential occupational risks within the prevocational doctor's workplace to patients and staff.
- OCCLP3.4 Describe how to report potential occupational risks within the prevocational doctor's workplace to patients and staff.

### 4. Professional and ethical role

- OCCLP4.1 Describe the personal health risks of medical practice such as fatigue and stress.
- OCCLP4.2 Outline the personal responsibilities of recognising the potential risk to others from your own health status.
- OCCLP4.3 Demonstrate communication with the patient's GP when appropriate.

### 5. Organisational and legal dimensions

- OCCLP5.1 Identify and describe the appropriate circumstances and situations requiring the completion of work insurance medical certificates, eg. Workcover.
- OCCLP5.2 Describe how patients may be treated in the private sector where workplace insurance, such as Workcover, is in place.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- OCCLV1.1 Demonstrate the use of advanced negotiating skills in managing small groups, including Workcover authority, employer, insurance companies and rehabilitation providers.
- OCCLV1.2 Describe the skills required for the management of stress in patients.
- OCCLV1.3 Demonstrate the ability to write legal reports.
- OCCLV1.4 Demonstrate how to give evidence in court.
- OCCLV1.5 Demonstrate how to manage telephone calls from employers.

### 2. Applied professional knowledge and skills

- OCCLV2.1 Demonstrate the management of common work related injuries.
- OCCLV2.2 Describe the content and implications of Workcover certificates.
- OCCLV2.3 Outline how to modify patient management to suit employer culture, where appropriate.

### 3. Population health and the context of general practice

- OCCLV3.1 Identify and describe strategies to overcome low use of specific services and preventive activities.
- OCCLV3.2 Record occupation in general practice patient records.
- OCCLV3.3 Identify and describe common occupational illnesses (including those relevant to your local area) including specific management or where to find this information.

### 4. Professional and ethical role

- OCCLV4.1 Describe the role of work insurance company authorised medical specialist agents, eg. health management specialists in Workcover.
- OCCLV4.2 Outline how to deal with competing priorities.
- OCCLV4.3 Demonstrate how to organise and review a completed functional capacity assessment.
- OCCLV4.4 Describe and implement OH&S related business regulations as they apply to a medical practice.

### 5. Organisational and legal dimensions

- OCCLV5.1 Demonstrate how to use relevant work related templates in medical software packages.
- OCCLV5.2 Demonstrate the ability to coordinate care involving multidisciplinary teams and to organise case conferences when required.
- OCCLV5.3 Describe patient confidentiality requirements and 'need to know' stakeholders to whom the patient has given the doctor permission to disclose, eg. insurance company and rehabilitation providers.
- OCCLV5.4 Describe practitioner legal responsibilities about when to report a worker as being unsafe to drive.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- OCCLC1.1 Outline the importance of maintaining a relationship with the patient and their experience of their illness or injury.
- OCCLC1.2 Describe how to act as a communicator and negotiator with third parties, validate and quantify the illness/injury, and ensure parties involved are aware of performance limitations where appropriate.

### 2. Applied professional knowledge and skills

- OCCLC2.1 Describe how work related injuries affect patient self esteem, confidence, income and family, and are often reinforced by feelings of vulnerability and rejection by the patient's peer group.
- OCCLC2.2 Outline how to take the issues in the previous objective into account in order to ensure full recovery and return to full function.
- OCCLC2.3 Outline how to deal with work related issues within the confines of the practical realities of the workplace and the patient's socioeconomic background.

### 3. Population health and the context of general practice

- OCCLC3.1 Describe health issues related to industries that are close to the locality of your practice.
- OCCLC3.2 Describe how to implement a program to reduce or ameliorate health impacts in the workplace.
- OCCLC3.3 Demonstrate contribution to promoting and protecting health, and preventing illness, injury and disability in the community.

### 4. Professional and ethical role

- OCCLC4.1 Demonstrate an ability to deal with multiple sources of work related information from patients, employers, specialists and members of the multidisciplinary team.
- OCCLC4.2 Describe how patients from disadvantaged socioeconomic and education backgrounds are particularly vulnerable to the negative impact of unemployment, financial hardship and family breakdown.
- OCCLC4.3 Demonstrate ability to manage OH&S in the practice environment.

### 5. Organisational and legal dimensions

- OCCLC5.1 Discuss how to work with other organisations on population based workers' health issues.
- OCCLC5.2 Describe obligations and limitations of OH&S related legislative requirements.
- OCCLC5.3 Demonstrate ongoing compliance with these OH&S related legislative requirements.

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## *Oncology*

### **Contents**

---

Definition	345
Curriculum in practice	345
Rationale and general practice context	346
Training outcomes of the five domains of general practice	347
Learning objectives across the GP professional life	350
<i>Medical student</i>	350
<i>Prevocational doctor</i>	351
<i>Vocational registrar</i>	352
<i>Continuing professional development</i>	353
References	354

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## Definition

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The general practice management of cancer involves caring for people with cancer and their carers over the entire spectrum of cancer control including:

- primary prevention such as advising smoking cessation and providing other behavioural advice about diet, weight control, physical activity and sun protection
- promoting and contributing to the delivery of national cancer screening programs for cervical, breast and colorectal cancer
- early detection, investigation, referral and management of symptomatic cancer and appropriate management of symptoms of potential oncological significance
- contributing to care during active treatment, in some cases through direct involvement in care delivery or in other instances through care coordination
- psychological support of patients and families throughout the patient's cancer journey
- early detection and management of recurrence of cancer or side effects of treatment including ongoing monitoring following treatment and through remission
- early detection and understanding for urgent management of cancer related emergencies such as neutropaenic sepsis, spinal cord compression, deep venous thrombosis and pulmonary emboli
- palliation of symptoms associated with the disease and its treatment.

## Curriculum in practice

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Typical cases that illustrate how the oncology curriculum applies to general practice include:

- A woman, 54 years of age, presents for a check up after her brother was diagnosed last week with bowel cancer. She says that an aunt had bowel cancer and that one of her grandfathers had died of the disease. She is now extremely worried about her risk of developing bowel cancer and is wondering what to do.
- One of your receptionists asks if you can fit in her 32 year old brother, Andy, who has noticed a lump at the angle of his jaw. The lump is firm rather than rubbery and adds a darkish tint to the overlying skin. Andy is an otherwise fit and active father of two who has been a keen surfer all his life. Although sporting sun damaged skin, he has no obvious malignant lesions and cannot recall ever having had a lesion removed. Due to the suspicious nature of the lump, you refer Andy to a surgeon and the resultant pathology is of a secondary malignant melanoma without known primary. The area is excised more widely, leaving him with significant cosmetic deformity. A PET scan is arranged and reveals multiple further small lesions in soft tissue and bone. He enters a research trial that requires him to undergo a combination of chemotherapy and radiotherapy. After an initial improvement, his lesions progress and his care becomes palliative.

## Rationale and general practice context

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Cancer is responsible for around 30% of deaths in Australia,<sup>1</sup> nearly 20% of the total burden of disease in Australia, as measured by death and disability.<sup>2</sup>

Malignant neoplasms account for 4.7 of every 100 general practice encounters, with skin cancers accounting for 1.1 of these encounters.<sup>3</sup> The rate of general practice cancer related services is increasing.<sup>4</sup>

Skin cancers, including basal and squamous cell carcinomas and melanomas, are the most common cancers managed by general practitioners. The next most common cancers in Australia are prostate, female breast, colorectal and lung cancers.<sup>1</sup>

Excluding nonmelanocytic skin cancers, around 108 368 new cases of cancer (62 019 males and 46 349 females) were diagnosed in Australia in 2006.<sup>5</sup> About 434 000 people are diagnosed with nonmelanocytic cancers each year.<sup>6</sup>

About two-thirds of the Australian population will develop at least one nonmelanocytic skin cancer in their lifetime<sup>6</sup> and 1 in 3 men and 1 in 4 women will develop a major cancer before the age of 75 years.<sup>1</sup> Cancer accounts for approximately 3 of every 10 deaths (29%) in Australia and although survival rates are improving, cancer accounts for nearly 40 000 deaths per year. In 2007, the risk of dying from cancer before the age of 75 years was 1 in 8 for males and 1 in 12 for females.<sup>5</sup>

While the number of deaths from cancer continues to rise, there is a decrease in the age standardised death rates in Australia.<sup>5</sup> However, despite these improvements, cancer is now Australia's leading cause of death among 45–64 year olds and causes more premature deaths and overall disease burden than cardiovascular disease.<sup>1</sup>

General practitioners require a professional and patient centred approach to enable them to support patients across the spectrum of cancer prevention and management.

### Related curriculum areas

Refer also to the curriculum statements:

- *Chronic conditions*
- *Multidisciplinary care*
- *Palliative care*
- *Population health and public health.*

# Training outcomes of the five domains of general practice

---

## 1. Communication skills and the patient-doctor relationship

- ONCT1.1 Use patient centred approaches to help develop strong relationships with patients and their families, to help provide support during the diagnosis and long term management of cancer.
- ONCT1.2 Apply specific communication skills including the ability to:
  - ONCT1.2.1 break bad news sensitively
  - ONCT1.2.2 discuss and explain management issues from a patient centred perspective
  - ONCT1.2.3 discuss the patient-doctor relationship openly to restore any loss in confidence that may have occurred due to a diagnosis of cancer.
- ONCT1.3 Identify and manage the psychosocial problems associated with a diagnosis of and the management of cancer.
- ONCT1.4 Discuss cancer risk and approaches to reducing risk and initiating behavioural change.
- ONCT1.5 Discuss the advantages and disadvantages of specific cancer screening tests and the interpretation of these tests.
- ONCT1.6 Empower patients to ask their oncologist about issues that are important for them, such as prognosis and quality of life.

## 2. Applied professional knowledge and skills

- ONCT2.1 Understand the assessment and minimisation of the lifestyle risk factors that contribute to cancer (ie. smoking, exposure to UV radiation, poor diet, insufficient physical activity and excessive alcohol consumption).
- ONCT2.2 Identify individuals at increased risk of cancer due to familial, behavioural or environmental risk factors.
- ONCT2.3 Assist patients to achieve lifestyle modifications (eg. quitting smoking) that will reduce their risk of cancer.
- ONCT2.4 Demonstrate the ability to perform skin checks and manage suspicious skin lesions.
- ONCT2.5 Obtain smoking and alcohol history and record this in the patient file.
- ONCT2.6 Monitor and record body mass index and dietary history as part of a cancer risk assessment.
- ONCT2.7 Understand the familial factors involved in increased risk of certain cancers.
- ONCT2.8 Use a three-generation family history to identify patients who are at increased risk of cancer.
- ONCT2.9 Be aware of National Health and Medical Research Council, Cancer Council and related evidence based guidelines on identifying those with an increased familial risk, and the role of surveillance programs, specific interventions and familial cancer clinics.
- ONCT2.10 Identify evidence based programs for the early detection of cancer.
- ONCT2.11 Be able to perform Pap tests with attention to quality assurance issues such as sterilisation of equipment and follow up of abnormal smears.
- ONCT2.12 Understand the presentation, diagnosis and management of common cancers in general practice.

- ONCT2.13 Demonstrate the ability to recognise significant symptoms that could be related to cancer and the appropriate pathways for investigation and referral of cancer.
- ONCT2.14 Have a broad understanding of the principles of management of common cancers, including side effects of common treatments, potential interactions, and how to access specialised knowledge when needed.
- ONCT2.15 Access information resources for patients to assist in their understanding of cancer and/or potential treatments.
- ONCT2.16 Understand the potential psychosocial sequelae of cancer that affect people with cancer and their carers, management of such issues and available support services.
- ONCT2.17 Identify those at risk and those with psychosocial problems.
- ONCT2.18 Have an awareness of evidence based guidelines.
- ONCT2.19 Obtain vital information from oncologists, such as prognosis, to help the patient regain control over management decisions that affect their quality of life.
- ONCT2.20 Understand the reasons for treatment pathway choices and manage common side effects.
- ONCT2.21 Have accurate and understandable information about cancer trials patients may wish to join.
- ONCT2.22 Explore the lived experiences of cancer patients with empathy and validation.

### 3. Population health and the context of general practice

- ONCT3.1 Broadly understand the epidemiology of common cancers in Australia, and particularly the role of risk factor modification and early detection of asymptomatic cancers; these are central to the role of general practice in reducing the impact of cancer in the community. This includes understanding:
  - ONCT3.1.1 that tobacco smoking is the leading cause of cancer, the range of cancers to which tobacco contributes and options to facilitate quitting
  - ONCT3.1.2 the relationship between ultraviolet radiation exposure and skin cancers
  - ONCT3.1.3 the evidence supporting the role of increased fruit and vegetables in the diet, increased physical activity, maintenance of a healthy body weight, and limiting or avoidance of alcohol in reducing the risk of certain cancers
  - ONCT3.1.4 the biological risk factors for cancer, including viruses such as hepatitis B and human papilloma virus (HPV)
  - ONCT3.1.5 the current evidence based guidelines in the primary care setting relating to healthy diet, physical activity and alcohol intake, including being able to assist patients to adopt preventive lifestyle behaviours.
- ONCT3.2 Have a broad understanding of cancer screening principles.
- ONCT3.3 Understand the evidence relating to screening tests for cervical, breast and colorectal cancer, including their pros and cons, appropriate use and follow up of abnormal screening tests.
- ONCT3.4 Understand the role of GPs in national screening programs (eg. BreastScreen and the National Bowel Cancer Screening Program), including the significance and management of a positive faecal occult blood test.
- ONCT3.5 Be aware of the complex issues surrounding testing for the early detection of prostate cancer and of the guidelines of organisations such as the Cancer Council Australia and the RACGP.
- ONCT3.6 Be able to describe the various community and consumer resources available for patients and their families affected by cancer.

## 4. Professional and ethical role

- ONCT4.1 Be able and prepared to act as a patient advocate when appropriate.
- ONCT4.2 Recognise the importance of patient autonomy and respecting patients' choices when making complex treatment and management decisions, which may include the decision to decline treatment.
- ONCT4.3 Support the patient's carers while maintaining the patient's right to confidentiality.
- ONCT4.4 Recognise the ethical issues associated with early detection of asymptomatic cancer.
- ONCT4.5 Liaise effectively with oncologists.
- ONCT4.6 Work professionally within a multidisciplinary team.
- ONCT4.7 Utilise evidence based guidelines to assist in the care of patients.

## 5. Organisational and legal dimensions

- ONCT5.1 Be aware of, and be able to access, relevant clinical guidelines for the prevention, early detection and treatment of cancer.
- ONCT5.2 Be aware of information sources for patients and carers.
- ONCT5.3 Maintain adequate clinical records and ensure appropriate follow up of significant symptoms that could be related to cancer.
- ONCT5.4 Be able to identify people at risk of cancer and utilise practice information systems (electronic and paper) to facilitate appropriate screening and surveillance.
- ONCT5.5 Be familiar with the legal implications of power of attorney and advanced treatment directives.
- ONCT5.6 Be aware of appropriate referral pathways for people with cancer within the local network.
- ONCT5.7 Be aware of local support services for people with cancer and their carers.
- ONCT5.8 Recognise the importance of care coordination and the need to act in a coordinating role if this is appropriate and desired by the patient and care team.
- ONCT5.9 Organise effective practice management systems to support the multidisciplinary team in managing cancer.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- ONCLM1.1 Describe the use of patient centred approaches to breaking bad news.
- ONCLM1.2 Describe the use of patient centred approaches to communicating cancer risk information and promoting healthy behaviours.

### 2. Applied professional knowledge and skills

- ONCLM2.1 Be able to perform a basic history and examination to assess symptoms associated with cancer.
- ONCLM2.2 Describe the usual presentations of common cancers.

### 3. Population health and the context of general practice

- ONCLM3.1 Describe the different national cancer screening programs.
- ONCLM3.2 Be able to conduct basic assessment of environmental, lifestyle and familial cancer risks.

### 4. Professional and ethical role

- ONCLM4.1 Outline the role of the GP within a multidisciplinary team that cares for people with cancer.
- ONCLM4.2 Outline the role of the GP as a patient advocate.

### 5. Organisational and legal dimensions

- ONCLM5.1 Outline the role of the GP in delivering cancer screening programs within the health system.
- ONCLM5.2 Describe the importance of maintaining adequate clinical records and follow up of patients with symptoms that could be related to cancer.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- ONCLP1.1 Recognise the psychological impact of a cancer diagnosis on patients and their families and demonstrate approaches to breaking bad news.

### 2. Applied professional knowledge and skills

- ONCLP2.1 Conduct a detailed assessment of cancer risk and provide basic advice on behaviour change to reduce risk.
- ONCLP2.2 Demonstrate knowledge of the presentation, diagnosis and management of common cancers in general practice.
- ONCLP2.3 Have a basic understanding of the management of common cancers and side effects.
- ONCLP2.4 Demonstrate appropriate investigation of symptoms associated with cancer.

### 3. Population health and the context of general practice

- ONCLP3.1 Implement national cancer screening programs in the hospital situation and be competent in conducting investigations (eg. a Pap test) as part of cancer screening.

### 4. Professional and ethical role

- ONCLP4.1 Describe the importance of patient autonomy and respect for patient choices when involved in complex decisions about their healthcare.
- ONCLP4.2 Demonstrate how to work professionally within a multidisciplinary team.

### 5. Organisational and legal dimensions

- ONCLP5.1 Outline appropriate referral pathways for people with cancer.
- ONCLP5.2 Outline the importance of local support services for people with cancer and their carers.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- ONCLV1.1 Demonstrate the ability to apply patient centred communication skills to support behaviour change to reduce cancer risk.
- ONCLV1.2 Demonstrate how to discuss different cancer screening tests and programs to support patients' informed choices.
- ONCLV1.3 Demonstrate an ability to discuss the importance of general practice care during and after active treatment of cancer.
- ONCLV1.4 Demonstrate the ability to communicate with patients and their families/carers about management, informed decisions and emotional issues.

### 2. Applied professional knowledge and skills

- ONCLV2.1 Describe the management of common cancers and the recognition and management of side effects of treatment.
- ONCLV2.2 Demonstrate how to apply patient centred care to manage the complex psychosocial issues of patients and families affected by a diagnosis of cancer.
- ONCLV2.3 Recognise and apply evidence based management for the assessment of symptoms associated with cancer.

### 3. Population health and the context of general practice

- ONCLV3.1 Demonstrate awareness of national cancer screening programs.
- ONCLV3.2 Describe the advantages and disadvantages of different cancer screening tests available in Australia.
- ONCLV3.3 Discuss the use of relevant clinical guidelines for the prevention, early detection and care of cancer.

### 4. Professional and ethical role

- ONCLV4.1 Describe the ethical issues associated with early detection of asymptomatic cancer.
- ONCLV4.2 Demonstrate use of evidence based guidelines to assist in the care of patients with cancer or those with symptoms related to cancer.
- ONCLV4.3 Describe the role of the GP as patient advocate for people with cancer and their carers.

### 5. Organisational and legal dimensions

- ONCLV5.1 Describe appropriate referral pathways for people with cancer or symptoms related to cancer.
- ONCLV5.2 Outline information sources for patients with cancer and their carers.
- ONCLV5.3 Describe the use of practice information systems to facilitate cancer screening and surveillance.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- ONCLC1.1 Demonstrate regular updating of communication skills in cancer related areas.
- ONCLC1.2 Describe approaches to empowering patients to ask their oncologists questions about their cancer care.

### 2. Applied professional knowledge and skills

- ONCLC2.1 Be able to identify gaps in knowledge, skills and attitudes in relation to evidence based cancer care and prevention.
- ONCLC2.2 Demonstrate keeping up-to-date with managing the side effects of treatment and cancer emergencies.

### 3. Population health and the context of general practice

- ONCLC3.1 Undertake to access ongoing professional development in relation to your identified knowledge gaps in cancer care and prevention.
- ONCLC3.2 Undertake to regularly update your knowledge and skill base in the light of any new and emerging evidence in cancer care and prevention.

### 4. Professional and ethical role

- ONCLC4.1 Demonstrate the role of patient advocate.
- ONCLC4.2 Demonstrate support for patients to make informed decisions about cancer screening and treatment.

### 5. Organisational and legal dimensions

- ONCLC5.1 Demonstrate incorporation of evidence based guidelines for the prevention, early detection and care of cancer within practice systems.
- ONCLC5.2 Maintain adequate clinical records and ensure appropriate follow up of significant symptoms that could be related to cancer.
- ONCLC5.3 Demonstrate the ability to identify people at risk of cancer and utilise practice information systems to facilitate appropriate screening and surveillance, including recall systems.
- ONCLC5.4 Use local support services to improve the care of people with cancer and their carers.

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## *Palliative care*

### Contents

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Definition	357
Curriculum in practice	357
Rationale and general practice context	358
Training outcomes of the five domains of general practice	360
Learning objectives across the GP professional life	363
<i>Medical student</i>	363
<i>Prevocational doctor</i>	364
<i>Vocational registrar</i>	365
<i>Continuing professional development</i>	366
References	367

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## Definition

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Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain and other symptoms, and psychological, social and spiritual issues, is paramount to provide the best quality of life for patients and their families.<sup>1</sup> Palliative care is also by definition 'team care'<sup>2</sup> and so careful assessment of symptoms and the needs of the patient should be undertaken by a multidisciplinary team.

The World Health Organization<sup>3</sup> defines palliative care as:

'An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family/carers cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families/carers, including bereavement counselling if indicated
- enhances quality of life, and may also positively influence the course of illness, and
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications'.

## Curriculum in practice

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The following typical presentation illustrates how the palliative care curriculum applies to general practice:

- Pete, 68 years of age, is a truck driver. He was forced into retirement due to lower back pain, which became severe enough to disturb his sleep. He managed his pain by increasing his alcohol intake, which led to marital problems culminating in separation. By the time he presented for review, he was living in a caravan and had several months of poor nutrition. Unfortunately his pain was found to be due to multiple myeloma, which proved resistant to treatment including bisphosphonates and a short course of radiotherapy. He has had a recent hospital admission for pneumonia and continues to smoke. His pain is currently well managed, however he does not take his other medications as recommended. This includes warfarin, which was commenced in hospital due to his limited mobility posing a risk of DVT. He rarely attends planned appointments, citing lack of transport, and you assess his psychosocial circumstance as placing him at high risk. As Pete's physical and emotional condition is likely to deteriorate as his disease advances, who can you involve in forward planning his future health needs?

## Rationale and general practice context

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Palliative care requires a multidisciplinary approach, with the general practitioner playing a central and increasing role, especially in the management of domiciliary care. For example, in 2002, of the approximate 134 000 deaths that occurred in Australia, about 64 000 (almost 50%) of patients would have been cared for by a GP several times during their last 12 months of life.<sup>4</sup>

Most patients who die an easily predictable death from a diagnosed terminal illness want to be cared for at home (>50%). However, only about 16% are able to exercise this option, as most patients now die in hospital; only 20% of people die in hospices and 10% in nursing homes.<sup>5</sup>

The community sector is increasingly caring for people at home rather than in hospital, and GPs often coordinate sometimes fragmented and competing community services and advocate on behalf of patients, their families and carers for community based palliative care.<sup>6,7</sup>

Like other doctors, GPs are largely trained to work with curative or life prolonging models of health and many GPs have identified that they require further education in the skills that underpin the practice of palliative care, such as basic communication skills, symptom control and management skills, and skills for dealing with 'death and dying'.<sup>8</sup>

The provision of good general practice and community based palliative care requires GPs to organise their practices appropriately to help build and configure best use of community based health networks (eg. specialist hospital based to community based teams) to meet the palliative care needs of their patients, and their families and carers, for quality, comprehensive healthcare at the end-of-life in the setting of their choice.<sup>9</sup>

Like any other area of medicine, GPs need to utilise evidence based clinical decisions when providing general practice palliative care and access current palliative evidence bases such as CareSearch<sup>10</sup> and *Therapeutic guidelines – palliative care*.<sup>11</sup>

There are government initiatives in palliative care, and GPs need to work in conjunction with government health priorities and other organisations toward better palliative care services.

### What are the core elements of general practice palliative care?

Core education requirements for the palliative care curriculum need to ensure<sup>12,13</sup>:

- physical aspects of care – close and detailed attention to symptom recognition and management, and knowledge of the pharmacology of medications, including dosing in elderly or renally impaired patients
- psychosocial aspects of care – emotional, social and spiritual aspects of end-of-life care, including developing specific communication skills needed to discuss end-of-life issues with patients and their families/carers
- cultural issues – crosscultural issues, appropriate use of independent interpreters
- ethical issues – state based legal requirements with death, wills and end-of-life issues, including managing requests for euthanasia and requests to hasten death with counselling and understanding
- teamwork – how to work in a multidisciplinary team, how to coordinate different models of care for best patient and family/carer outcomes
- practical issues – practice issues around 24 hour care rostering, and appropriate use of Medicare Benefits Schedule items to sustainably practise equitable palliative care for patients, determined on the basis of need

- carer support – respite arrangements, depression screening and support, emotional support and bereavement care, and understanding and recognising risk factors that may predict the early onset of psychosocial distress and complicated grief reactions<sup>14</sup> in family members and carers to enable appropriate referral for further psychosocial support
- career-long learning – critical appraisal of the evidence base used for own practice and developing primary palliative care research skills to update own evidence base, as well as developing community education, advocacy and health promotional skills
- complementary and alternative medicine<sup>15,16</sup> – developing skills to help patients and their families/ carers to be able to assess their own use of complementary therapies from an evidence based and/or safe perspective
- audit, care pathway and outcome measurement – developing skills to measure own practice in the area of palliative care (eg. developing an end stage care pathway audit tool<sup>17</sup>) and be able to audit clinician use of symptom assessment lists and outcome measures (eg. pain scales).

## Related curriculum areas

- *Oncology*
- *Pain management.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- PALT1.1 Establish and foster effective and empowering relationships with patients and their families as partners in care decisions, as well as with other healthcare professionals.
- PALT1.2 Use good communication skills including active listening, breaking bad news, dealing with difficult questions, discussing end-of-life issues and crosscultural care at the end-of-life.
- PALT1.3 Understand the experience and consequences of disease from the perspective of the patient and their family.
- PALT1.4 Help patients live as creatively and meaningfully as possible all the way to the end-of-life.
- PALT1.5 Be sensitive to differing perceptions and expectations of disease and treatment among various family members.
- PALT1.6 Be aware of spiritual, religious and cultural issues.
- PALT1.7 Understand the normal process of grief, help prepare carers for bereavement and offer support during this process.

## 2. Applied professional knowledge and skills

- PALT2.1 Use evidence based clinical decisions when providing general practice palliative care and access current palliative evidence bases (eg. CareSearch and *Therapeutic guidelines – palliative care*).
- PALT2.2 Appreciate and understand the broad range of terminal illnesses (eg. malignancy), neurological degenerative disease (eg. motor neurone disease, end stage dementia), organ failure (eg. chronic obstructive pulmonary disease, congestive cardiac failure), frailty and dementia, and HIV/AIDS.
- PALT2.3 Understand the potential treatments available, both disease specific and for symptom control, including palliative surgery, radiotherapy and chemotherapy.
- PALT2.4 Anticipate, diagnose and manage potential problems, either disease related or iatrogenic.
- PALT2.5 Understand indicators of disease progression.
- PALT2.6 Demonstrate a good understanding of drugs commonly used in palliative care (indications, doses, side effects, routes of administration).
- PALT2.7 Be familiar with the use of appropriate subcutaneous infusion devices in palliative care.
- PALT2.8 Understand the implications of renal and hepatic impairment.
- PALT2.9 Be familiar with dose equivalence of opioids and be able to recognise signs of opioid toxicity.
- PALT2.10 Be aware of possible interactions between prescribed drugs and any complementary and alternative medicines patients may be taking, or be able to refer to available databases to advise patients on the available evidence of efficacy, safety and adverse interactions.
- PALT2.11 Identify symptoms and therapeutic responses (including counselling and psychosocial support).

- PALT2.12 Be able to diagnose and identify the causes and appropriately manage common symptoms of many end-of-life conditions including:
- PALT2.12.1 pain (nociceptive, visceral, neuropathic and complex)
  - PALT2.12.2 nausea and vomiting
  - PALT2.12.3 constipation
  - PALT2.12.4 anorexia
  - PALT2.12.5 hiccups
  - PALT2.12.6 fatigue, weakness and lethargy
  - PALT2.12.7 mouth care
  - PALT2.12.8 delirium and confusion
  - PALT2.12.9 dyspnoea
  - PALT2.12.10 depression and anxiety
  - PALT2.12.11 existential distress
  - PALT2.12.12 pressure area care
  - PALT2.12.13 malignant effusions
  - PALT2.12.14 peripheral lymphoedema
  - PALT2.12.15 terminal phase events (eg. agitation, distress, 'noisy breathing', restlessness, haemorrhage and seizure).
- PALT2.13 Be competent in recognising and appropriately managing and/or referring on patients with potential emergencies at the end-of-life such as:
- PALT2.13.1 opioid toxicity (especially in renal failure)
  - PALT2.13.2 neutropaenic sepsis
  - PALT2.13.3 hypercalcaemia
  - PALT2.13.4 bowel obstruction
  - PALT2.13.5 seizure
  - PALT2.13.6 spinal cord compression
  - PALT2.13.7 haemorrhage.

### 3. Population health and the context of general practice

- PALT3.1 Be aware of the services available within the community and the means of accessing these services.
- PALT3.2 Coordinate these services in the care of the patient and also consider health beyond that of the individual patient. This involves an advocacy role regarding community needs, including promoting the needs of disadvantaged groups. Part of this may involve developing crosscultural partnerships.
- PALT3.3 Be aware of the needs for bereavement support, and appropriate referral or management of complicated grief reactions.
- PALT3.4 Help allocate finite healthcare resources prudently to best serve the health needs of the population on the basis of need and equity of access to care and support.

## 4. Professional and ethical role

- PALT4.1 Display a professional attitude and be able to analyse and understand the ethical dimensions of clinical scenarios in palliative care.
- PALT4.2 Negotiate and agree on treatment modalities, priorities and goals of treatment.
- PALT4.3 Respect patient wishes to decline treatment.
- PALT4.4 Understand the issues surrounding euthanasia, 'relief of suffering' at the end-of-life, and patient and community perspectives on a 'good death'.
- PALT4.5 Understand the issues surrounding advance health directives and end-of-life planning, including the need to complete 'unfinished business'.
- PALT4.6 Be prepared to advocate strongly for patient needs.
- PALT4.7 Reflect on own personal beliefs and the impact of these on interactions with patients and their care.
- PALT4.8 Have an ongoing commitment to professional development that promotes the best available evidence based practice. Use this knowledge to provide patients with the best management.
- PALT4.9 Be aware of and respect how the spiritual, religious and cultural issues specific to each patient affects their perception of illness and death, and treatment decisions made in partnership with the patient and their family/carers.
- PALT4.10 Recognise any personal emotional stress and seek assistance appropriately.
- PALT4.11 Communicate effectively within multidisciplinary teams, including community organisations and administrative bodies, to promote quality care and optimise palliative care health outcomes.
- PALT4.12 Advocate, where appropriate, on behalf of patients.

## 5. Organisational and legal dimensions

- PART5.1 Understand the complexities of, and commitment to, working as part of a multidisciplinary team.
- PART5.2 Be able to work with several models of healthcare and service delivery, and be able to coordinate and integrate these services collaboratively and seamlessly for the best care of the patient.
- PART5.3 Be aware of local medical, nursing, allied health, community and respite services.
- PART5.4 Be able to locally access appliances as aids to daily living for patients.
- PART5.5 Be familiar with state legal requirements for:
  - PART5.5.1 carer's allowances
  - PART5.5.2 advance health directives
  - PART5.5.3 enduring power of attorney/enduring power of guardianship
  - PART5.5.4 preparation of a will.
- PART5.6 Be familiar with identification and certification of death, and surrounding legal issues.
- PART5.7 Structure the clinic/practice to accommodate home visits for palliative patients, when appropriate, and arrange adequate clinical handover to partners or preferred after hours providers to ensure continuity of care at all hours for palliative care patients and their families.
- PART5.8 Be aware of nontime based Medicare Benefits Schedule (MBS) items that reward team care and planning.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- PALLM1.1 Describe specific communication skills to be able to best care for patients and their families/carers at the end-of-life, and the families/carers progress beyond the patient's death during their bereavement phase.

### 2. Applied professional knowledge and skills

- PALLM2.1 Describe the pathology, including both malignant and nonmalignant terminal and chronic illness, and some understanding of prognosis and quality of life issues.
- PALLM2.2 Describe the anatomical and physical aspects of incurable, life-limiting disease processes.
- PALLM2.3 Outline how a significant proportion of patients with incurable diseases require the doctor to exhibit skills for 'caring' rather than 'curing' and how to help patients and their families/carers to prioritise care on the basis of quality of life.

### 3. Population health and the context of general practice

- PALLM3.1 Describe the role of the GP in the palliative care setting and GPs operating within a multidisciplinary framework to provide palliative care to patients from a holistic, physical, psychosocial and spiritual perspective.

### 4. Professional and ethical role

- PALLM4.1 Be able to seek help and care for one's own physical, emotional, social and spiritual needs in this emotionally challenging area of work.

### 5. Organisational and legal dimensions

- PALLM5.1 Outline team care and care planning arrangements that are possible for both funding and organising care in the general practice palliative care setting.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- PALLP1.1 Demonstrate skills in taking a thorough history (physical, emotional, psychosocial and spiritual) in a patient with a life-limiting illness.
- PALLP1.2 Demonstrate skills in competently communicating 'bad news' and discussing prognosis, and empathically being able to redefine realistic goals for 'hope' and 'care' at the end-of-life.

### 2. Applied professional knowledge and skills

- PALLP2.1 Demonstrate skills in being able to elicit reporting of common symptoms seen in palliative care, be able to use symptom checklists and screening tools when needed, and organise a prioritised management checklist in line with the patient's and/or their family's wishes.
- PALLP2.2 Demonstrate skills in being able to organise appropriate investigations in a palliative patient, taking into consideration the context of the patient's illness.
- PALLP2.3 Demonstrate skills in being able to perform a thorough examination in a patient with a life-limiting illness.
- PALLP2.4 Describe the drugs commonly used in palliative care and their indications, doses and routes of administration.

### 3. Population health and the context of general practice

- PALLP3.1 Describe how to assess and describe each patient's links to family and friends.
- PALLP3.2 Demonstrate an ability to advocate for equity of access to multidisciplinary palliative care services, particularly for those from disadvantaged groups and their families/carers.

### 4. Professional and ethical role

- PALLP4.1 Demonstrate skills in being able to devise comprehensive management plans in partnership with patients and their families/carers to enhance quality of life at the end-of-life.
- PALLP4.2 Describe self care measures in place for the treating GP and other care team members.

### 5. Organisational and legal dimensions

- PALLP5.1 Demonstrate familiarity with completing death certificates, advanced health directives, enduring guardianship requirements, carer's allowance applications and other legislative and administrative requirements relevant to palliative care and end-of-life issues.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- PALLV1.1 Demonstrate awareness in defining the realistic context of illness at the end-of-life for the patient and their family.
- PALLV1.2 Demonstrate specific communication skills in dealing with end-of-life issues such as giving bad news, counselling regarding realistic expectations and hope, nutrition and hydration, and exploring and managing requests for euthanasia.

### 2. Applied professional knowledge and skills

- PALLV2.1 Demonstrate skills in managing bereavement issues for families/carers and coordinating services to meet these needs when ongoing care and support is required.
- PALLV2.2 Demonstrate management skills in dealing with the psychological, social, cultural and spiritual aspects of the patient's illness and the impact of these on patient care.

### 3. Population health and the context of general practice

- PALLV3.1 Demonstrate establishment of relationships and networks with other community services that are necessary to provide quality palliative care (eg. nursing, allied health and domiciliary services) equitably across the local population as needed.

### 4. Professional and ethical role

- PALLV4.1 Demonstrate skills in dealing with ethical issues in patient care at the end-of-life.

### 5. Organisational and legal dimensions

- PALLV5.1 Demonstrate the ability to lobby local health service providers to provide essential health services for palliative care patients, as needed, in the patient or carer's preferred place of care.
- PALLV5.2 Demonstrate the ability to advocate on behalf of patients in relation to meeting their palliative care needs.
- PALLV5.3 Demonstrate awareness of the palliative care services available in the patient's community, and be able to access these services to optimise patient care.
- PALLV5.4 Demonstrate familiarity with completing death certificates, advanced health directives, enduring guardianship requirements, carer's allowance applications and other legislative and administrative requirements relevant to palliative care and end-of-life issues in the general practice setting.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- PALLC1.1 Demonstrate a commitment to upskilling regularly in communication skills acquisition associated with managing challenging end-of-life issues for patients and their families/carers.

### 2. Applied professional knowledge and skills

- PALLC2.1 Demonstrate evidence of updating own knowledge and skill base in the light of new and emerging evidence in palliative care.

### 3. Population health and the context of general practice

- PALLC3.1 Describe the demographics of terminal illness, especially in relation to nonmalignant conditions.
- PALLC3.2 Demonstrate a commitment to forging and maintaining relationships with other community palliative care service providers to provide equity of access on the basis of need.
- PALLC3.3 Demonstrate access to current palliative evidence bases (eg. CareSearch and *Therapeutic guidelines – palliative care*).
- PALLC3.4 Describe and implement, where appropriate, policies and standards for palliative care.

### 4. Professional and ethical role

- PALLC4.1 Demonstrate planning on how to undertake ongoing professional development in relation to identified palliative care knowledge gaps.

### 5. Organisational and legal dimensions

- PALLC5.1 Demonstrate the ability to identify gaps in own knowledge, skills and attitudes in relation to evidence based palliative care.
- PALLC5.2 Outline practice financial aspects and time management issues related to effective palliative care general practice service provision.
- PALLC5.3 Undertake regular audits of management practices in dealing with palliative care patients and their families/carers.

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## *Pain management*

### Contents

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Definition	371
Curriculum in practice	371
Rationale and general practice context	372
Training outcomes of the five domains of general practice	373
Learning objectives across the GP professional life	374
<i>Medical student</i>	374
<i>Prevocational doctor</i>	376
<i>Vocational registrar</i>	378
<i>Continuing professional development</i>	380
References	382

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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The Royal Australian College of General Practitioners

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## Definition

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Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.<sup>1</sup>

Pain is always subjective and each person's individual experience of pain is related to their life experiences, such as injury in early life.

Stimuli that cause pain may be associated with actual or potential tissue damage. While this sensation in itself may be unpleasant, there is also an accompanying emotional experience including fear.

Patients who are unable to communicate verbally can still experience pain and may need appropriate pain relieving treatment.

Some people report pain in the absence of tissue damage or any likely pathophysiological cause, which may indicate a psychological basis. Based on subjective reports, there may be no way to distinguish their experience from that due to tissue damage. If a patient regards their experience as pain, and if they report it in the same ways as pain caused by tissue damage, this should be accepted as pain. This definition avoids tying pain to the stimulus.

Experiences that resemble pain but are not unpleasant, such as pricking, should not be called pain. Unpleasant abnormal experiences (dysesthesias) may also be pain, but are not necessarily so because subjectively they may not have the usual sensory qualities of pain. There is a wide range of terms to describe types of pain and pain related symptoms.<sup>1</sup>

## Curriculum in practice

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The following case illustrates how the pain management curriculum applies to general practice:

- Graham, 34 years of age, is a telecommunications linesman who injured his back 18 months ago when a colleague abruptly dropped a heavy coil they were jointly lifting. The pain was instantaneous and severe, but without motor weakness. He spent 4 days in hospital before being able to mobilise sufficiently to be discharged. Since then he has continued to have low back pain with morning stiffness and a sciatic referral pattern if he coughs or sneezes. Walking or standing for any length of time triggers muscle spasms so he spends most of his time lying on his back with a pillow under his knees. He is able to dress himself, but is unable to bend over to put on his shoes so wears slip-on thongs. Previously, he was a fit man, but is now overweight and his wife is concerned that he may also be depressed. As he was no longer able to take care of their yard they have moved to be closer to their son. Physiotherapy appeared to help initially, but Graham no longer believes it is beneficial. He hates taking analgesia due to constipation, but will use over-the-counter codeine medications for severe bouts, in conjunction with alcohol.

## Rationale and general practice context

Pain is associated with many general practice conditions, and diagnosis and management is often poorly understood and undertreated.

Patients in pain and their carers may feel hopeless, helpless, deserted and angry and doctors may experience frustration when pain fails to respond to treatment.

General practitioners manage the majority of patients with pain in Australia for both front line and last resort in pain management. Expertise in pain management is developed through education and exposure to clinical experience. Specialist advice in pain management can supplement general practice competence but cannot replace it. Interdisciplinary approaches are often helpful.

Pain is a very common general practice problem.<sup>2</sup> The National Health Survey 2007–2008<sup>3</sup> of adults over 18 years of age reported that 9.7% of participants said that they had severe or very severe pain; 19.3% said that they had moderate pain, and 39.1% reported mild or very mild pain. These levels of pain were associated with varying levels of disability as listed in *Table 1*.

	Level of reported disability associated with pain (%)			
Bodily pain experienced	Profound or severe activity limitation	Other disability or restrictive long term health condition	Has no disability or restrictive long term health condition	Total
None	11.5	16.9	43.4	31.9
Very mild or mild	21.0	38.3	41.2	39.1
Moderate	29.0	30.2	11.4	19.3
Severe or very severe	38.6	14.6	4.0	9.7

Table 1. Adults with body pain, as reported in the National Health Survey 2007–8, Australian Bureau of Statistics<sup>3</sup>

### Related curriculum areas

Refer also to the curriculum statements:

- *Acute serious illness and trauma*
- *Chronic conditions*
- *Musculoskeletal medicine*
- *Palliative care.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- PAIT1.1 Use patient centred approaches and clear communication between the patient and doctor that acknowledge how the subjective nature of pain presents many diagnostic and management challenges to the general practitioner.
- PAIT1.2 Use careful and close communication to monitor therapeutic progress and maximise success of pain management outcomes.
- PAIT1.3 Know how patient perceptions of pain are influenced by a complex range of factors, including past experience of pain, medication history, family, culture, social and occupational history and how this can sometimes make communication challenging.
- PAIT1.4 Incorporate a knowledge of how differing expressions and understandings of pain across cultures can sometimes make communication challenging.

## 2. Applied professional knowledge and skills

- PAIT2.1 Have a wide knowledge of pain management in a wide range of medical conditions, including undifferentiated problems.
- PAIT2.2 Understand how information gathering and examination skills are critical for clinical for managing pain management.
- PAIT2.3 Integrate pain management into all aspects of general practice clinical work when appropriate, especially in continuity of patient care.
- PAIT2.4 Understand the potential significant long term challenges that pain management may present to the GP's skills, in particular, chronic pain.

## 3. Population health and the context of general practice

- PAIT3.1 Understand that general practice is both the front line and the last resort in pain management.
- PAIT3.2 Understand how pain is one of the most common and diverse presentations in general practice and a significant cause of patient morbidity, as well as affecting the wellbeing of family and carers.
- PAIT3.3 Understand the cultural, social, family and work factors that play a significant role in its daily management in general practice.

## 4. Professional and ethical role

- PAIT4.1 Know the professional and legal requirements that have a significant affect on chronic pain management.
- PAIT4.2 Work, as a GP, in close coordination with other professionals within a multidisciplinary team for successful pain management outcomes.

## 5. Organisational and legal dimensions

- PAIT5.1 Ensure ongoing practice availability and accessibility arrangements to help alleviate patient suffering.
- PAIT5.2 Know how organisational systems ensure that patients with pain are regularly monitored, as well as ensuring that all legislative requirements around analgesia are met.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- PAILM1.1** Outline how the relationship between the patient and the doctor is central to a good therapeutic outcome in pain management.
- PAILM1.2** Outline the difficulties in communicating the pain experience.
- PAILM1.3** Outline patient fears and attitudes toward pain medication use and methods to discuss these.
- PAILM1.4** Describe how pain is a personal experience and that there are differences between people who are influenced by age, gender, culture and other factors.
- PAILM1.5** Describe how lifestyle choices may assist the patient to manage pain.

### 2. Applied professional knowledge and skills

- PAILM2.1** Describe the processes of nociception, pain transmission, peripheral sensitisation and central sensitisation.
- PAILM2.2** Describe the differences between nociceptive, neuropathic and visceral pain and the implications of these for diagnosis and management.
- PAILM2.3** Outline the burden of pain related disability.
- PAILM2.4** Outline how pain often accompanies disease processes.
- PAILM2.5** Describe the psychological influences and consequences of pain problems that are poorly understood by the medical profession.
- PAILM2.6** Demonstrate how to obtain and record a systematic history that includes site, severity, quality, timing, progression, radiation, aggravating and relieving factors.
- PAILM2.7** Demonstrate how to examine a patient to exclude serious and life threatening conditions and differentiate between nociceptive, chronic musculoskeletal, neuropathic and visceral pain.
- PAILM2.8** Demonstrate a targeted diagnostic approach that screens for serious causes of pain and psychosocial risk factors.
- PAILM2.9** Outline the role of an interdisciplinary approach to pain management.
- PAILM2.10** Describe the technical aspects and costs of commonly used imaging modalities including their potential for patient discomfort.
- PAILM2.11** Classify the major groups of medications used in pain management.
- PAILM2.12** Outline different formulations of pain medications (eg. oral, rectal, intramuscular, subcutaneous, intravenous and epidural formulations).
- PAILM2.13** Demonstrate how to access, interpret and use the best available evidence available in the pain management literature.

### 3. Population health and the context of general practice

- PAILM3.1 Describe the diversity of chronic pain sufferers.
- PAILM3.2 Describe how women report pain more than men, and how and why women are at more risk of chronic pain disorders.
- PAILM3.3 Describe how men are at greater risk for some pain disorders (eg. cluster headaches and pancreatitis).
- PAILM3.4 Describe how pain thresholds vary depending upon psychosocial and other factors.
- PAILM3.5 Outline how the needs of patients vary as does their ability to access care.
- PAILM3.6 Describe how poor pain management may be the result of sociopolitical and cultural values.
- PAILM3.7 Describe how suffering due to pain is strongly influenced by 'what the pain means' not only to the patient in pain, but to their significant others.
- PAILM3.8 Outline how pain management may include community services.

### 4. Professional and ethical role

- PAILM4.1 Describe how chronic pain management is a new and developing area and how doctors need to regularly review changes in appropriate drug use and treatment strategies.
- PAILM4.2 Describe how pain management requires regular monitoring of effectiveness in improving quality of life.
- PAILM4.3 Describe how pain causes distress and distressed patients frequently produce emotional feelings in the doctor.
- PAILM4.4 Outline how pain strains the capacity of individuals and relationships.

### 5. Organisational and legal dimensions

- PAILM5.1 Describe how pain occurs at any time and that accessible and available care is important in reducing anxiety.
- PAILM5.2 Outline how barriers to care can exacerbate the distress associated with pain.
- PAILM5.3 Describe the therapeutic role of screening and recall for reassessment in pain management.
- PAILM5.4 Outline how monitoring a condition requires recording a baseline to measure change against.
- PAILM5.5 Outline the legal requirements in managing Schedule 8 medications.
- PAILM5.6 Outline how Schedule 8 medications require regular reporting, and may require certification and reporting of confidential information.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- PAILP1.1 Demonstrate a compassionate approach to pain and suffering.
- PAILP1.2 Identify the psychosocial risk factors for successful pain management.
- PAILP1.3 Recognise that words cannot completely convey the patient's pain experience.
- PAILP1.4 Describe how a clinician's personal attitudes to pain can affect the patient-doctor relationship.

### 2. Applied professional knowledge and skills

- PAILP2.1 Demonstrate how to diagnostically differentiate between nociceptive, neuropathic and visceral pain and how to justify such a diagnosis.
- PAILP2.2 Demonstrate how to make an appropriate referral for patients with undifferentiated pain problems.
- PAILP2.3 Demonstrate how to take a history to exclude 'red flag' conditions and differentiate between nociceptive, chronic musculoskeletal, neuropathic and visceral pain.
- PAILP2.4 Show how to perform an examination to exclude red flag conditions and differentiate between nociceptive, chronic musculoskeletal, neuropathic and visceral pain.
- PAILP2.5 Demonstrate the management of acute nociceptive and visceral pain with appropriate pharmacological and nonpharmacological measures.
- PAILP2.6 Describe the strengths and limitations of commonly used imaging modalities in determining the cause of pain.
- PAILP2.7 Show how to use the major groups of pain medications in common acute and chronic pain conditions.
- PAILP2.8 Describe the pharmacology of regimens of common painkillers including those for children and infants.
- PAILP2.9 Recognise that treatment is easier if a patient understands the aetiology, management and prognosis of their pain.
- PAILP2.10 Identify resources for pain management.
- PAILP2.11 Outline other nonpharmacological pain management approaches.
- PAILP2.12 Demonstrate the application of the results of an online literature search to answer clinical questions about pain diagnosis and treatment.

### 3. Population health and the context of general practice

- PAILP3.1 Outline the numbers of people with chronic pain in the community.
- PAILP3.2 Outline the prevalence and incidence of common pain syndromes in the general population.
- PAILP3.3 Describe the pain management needs of older people and the dying.
- PAILP3.4 Identify ways to work within the local cultural expectations to maximise the benefits for the individual patient.
- PAILP3.5 Outline the loss of worth arising from lack of employment, or the loss of societal interaction and its subsequent effects on health.

### 4. Professional and ethical role

- PAILP4.1 Describe how to deal with personal attitudes toward pain management and develop an appreciation of how these may influence clinician decision making.
- PAILP4.2 Outline how patients have a right to adequate pain relief.
- PAILP4.3 Describe the difference between addiction and chronic medication use.
- PAILP4.4 Outline how the large volume of current research into pain management may alter treatment.
- PAILP4.5 Contribute to an interdisciplinary approach to pain management.
- PAILP4.6 Describe how some pain management requires a team approach.

### 5. Organisational and legal dimensions

- PAILP5.1 Identify barriers to pain management.
- PAILP5.2 Describe how to ensure continuity of care.
- PAILP5.3 Assess approaches to providing continuous care.
- PAILP5.4 Evaluate the strengths and weakness of individual or team care.
- PAILP5.5 Investigate approaches that monitor outcomes.
- PAILP5.6 Compare opportunistic and scheduled assessment approaches.
- PAILP5.7 Consider how to measure and record change.
- PAILP5.8 Decide on parameters that indicate change.
- PAILP5.9 Establish and record treatment and alternative options considered.
- PAILP5.10 Demonstrate an awareness of community services that can assist overall management.
- PAILP5.11 Detail the requirements for initiating and maintaining treatment with Schedule 8 medications.
- PAILP5.12 Understand the local, state and commonwealth requirements in prescribing and administering Schedule 8 medications.
- PAILP5.13 Describe approaches to meet legal requirements.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- PAILV1.1 Describe the psychological influences and consequences of acute and chronic pain.
- PAILV1.2 Demonstrate the ability to recognise the patient's needs and wants in terms of their pain management.
- PAILV1.3 Describe the role of the placebo response in pain management.
- PAILV1.4 Outline the differences between pain perception, suffering and pain behaviour in those from different cultures and backgrounds.
- PAILV1.5 Demonstrate the skills and attitudes required for effective whole person care.
- PAILV1.6 Describe how clinician attitudes, beliefs and feelings may affect pain management.
- PAILV1.7 Describe information sources that may assist patients in pain to better manage their condition.

### 2. Applied professional knowledge and skills

- PAILV2.1 Demonstrate a working knowledge of the frequency of different types of pain presentations in general practice.
- PAILV2.2 Describe the difference between pain perception, suffering and pain behaviour.
- PAILV2.3 Describe common patterns of pain referral and their clinical implications.
- PAILV2.4 Demonstrate a short term strategy for dealing with undifferentiated pain problems.
- PAILV2.5 Demonstrate history taking that addresses psychosocial factors and consequences of pain.
- PAILV2.6 Assess the type and degree of pain related disability.
- PAILV2.7 Perform an examination for generalised pain syndromes.
- PAILV2.8 Justify the use of physical examination tests for pain.
- PAILV2.9 Demonstrate the ability to document the pain presentation in terms of site and radiation, duration, quality, severity, associated signs and symptoms.
- PAILV2.10 Demonstrate the management of nociceptive, chronic musculoskeletal, neuropathic and visceral pain with appropriate pharmacological and nonpharmacological measures.
- PAILV2.11 Demonstrate incorporation of pain related disability into diagnostic and management decisions about pain.
- PAILV2.12 Demonstrate integration of pharmacological and nonpharmacological approaches to pain management.
- PAILV2.13 Demonstrate rational prescribing of complex regimes of pain medications.
- PAILV2.14 Outline the strengths and limitations of commonly used history and examination items used for pain assessment history and examination.

### 3. Population health and the context of general practice

- PAILV3.1 Analyse the diversity of chronic pain sufferers within the clinician's own patient population.
- PAILV3.2 Describe how general practice pain management is different to the hospital setting because of the common occurrence of undifferentiated pain presentations in the community setting.
- PAILV3.3 Outline how different manifestations and management needs for children and the elderly with pain.
- PAILV3.4 Outline how cultural values and beliefs may affect management outcomes when prescribing treatments and offering management techniques.
- PAILV3.5 Describe how a patient's family and employment can act as both a support and a liability in overall pain management.

### 4. Professional and ethical role

- PAILV4.1 Outline the patient's right to privacy.
- PAILV4.2 Outline how to balance an individual's right to privacy and the community's right to protect its members from harm.
- PAILV4.3 Describe the situations when pain management requires a multidisciplinary approach.
- PAILV4.4 Describe the legal obligations of the doctor in prescribing for pain management.
- PAILV4.5 Understand community concerns about the narcotic debate and the influence this has on perceptions of both patients and families.
- PAILV4.6 Appreciate that discussion with other medical practitioners may assist with drug management, but that emotional support for both patient and doctor can come from a much wider range of members of society.
- PAILV4.7 Outline the influence of culture and ethnicity on pain perception and management.
- PAILV4.8 Recognise that clinician self reflection is critical to improving pain management.

### 5. Organisational and legal dimensions

- PAILV5.1 Demonstrate the development of mechanisms to ensure ongoing access to care.
- PAILV5.2 Describe the role of team management in providing care.
- PAILV5.3 Identify local services that may offer assistance to people experiencing pain (eg. stress management, yoga and meditation classes).
- PAILV5.4 Identify potential gaps in care arrangements.
- PAILV5.5 Develop systems to identify unmet need.
- PAILV5.6 Develop and implement systems to recall and review patients and to monitor change in function and quality of life.
- PAILV5.7 Establish baseline levels of pain from which a patient's functional changes can be measured such as improvement or deterioration.
- PAILV5.8 Identify practice management issues relating to drugs of dependence medication prescription and dispensing.
- PAILV5.9 Demonstrate the sharing of responsibility of pain management with patients including educating patients on legal limitations on treatment options.
- PAILV5.10 Describe the learning process to ensure up-to-date knowledge of drug schedules (especially drugs of dependence), and commonwealth, state and other legislative requirements.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- PAILC1.1 Demonstrate the ability to coordinate a multidisciplinary team approach for a patient's pain management.

### 2. Applied professional knowledge and skills

- PAILC2.1 Demonstrate evidence based approach to an individual's pain management.
- PAILC2.2 Describe the features of central and peripheral sensitisation in chronic pain states.
- PAILC2.3 Evaluate the response of patients to pain interventions and adjust practice in accordance with this evaluation.
- PAILC2.4 Describe the differences in the neurobiology of pain in children and older people.
- PAILC2.5 Demonstrate a consideration of the distinctive pain management requirements of children and the elderly.
- PAILC2.6 Demonstrate how to recognise and manage pharmacological dependence in patients with chronic pain.
- PAILC2.7 Demonstrate the use of simple measures to monitor pain and related disability in practice over time.
- PAILC2.8 Monitor the use of investigations for pain and justify their use.
- PAILC2.9 Outline the strengths and limitations of commonly used investigations for pain assessment.
- PAILC2.10 Demonstrate openness to using new medications and techniques and evaluating their appropriateness as they become available.
- PAILC2.11 Demonstrate a holistic long term strategy for dealing with undifferentiated pain problem.
- PAILC2.12 Demonstrate the coordination of care for complex pain patients.
- PAILC2.13 Document a comprehensive management plan for acute and chronic pain incorporating a stepped pharmacological plan and effective nonpharmacological measures.

### 3. Population health and the context of general practice

- PAILC3.1 Identify the population of patients who may be susceptible to chronic pain.
- PAILC3.2 Identify the prevalence of chronic pain within the clinician's general practice population.
- PAILC3.3 Outline the socioeconomic burden of pain.
- PAILC3.4 Identify areas of need in healthcare resources and act upon them for improved health outcomes for those with special needs.
- PAILC3.5 Demonstrate an awareness of the diversity of cultural backgrounds within Australian society when dealing with pain issues.
- PAILC3.6 Evaluate the psychosocial aspects of pain management in health advocacy.
- PAILC3.7 Demonstrate an ability to upskill ancillary services within the community that can then benefit patients with chronic pain.

## 4. Professional and ethical role

- PAILC4.1 Demonstrate a deeper understanding of the pain management dilemmas, which may be more appropriate to the GP's particular patient population.
- PAILC4.2 Demonstrate an awareness of developments and research in pain and its management.
- PAILC4.3 Demonstrate keeping up-to-date with governmental and legislative changes.
- PAILC4.4 Demonstrate keeping up-to-date with changing community attitudes.
- PAILC4.5 Further explore and describe the influence of culture and ethnic backgrounds on pain perception.
- PAILC4.6 Demonstrate discussion of patient safety issues with colleagues to ensure that treatments are appropriate and errors in prescribing are avoided.
- PAILC4.7 Demonstrate how to teach patient, family and carers about pain management.
- PAILC4.8 Describe the challenges involved with working with other GPs and specialist pain management services.

## 5. Organisational and legal dimensions

- PAILC5.1 Demonstrate the establishment of a risk management process to review a patient's ability to access pain management.
- PAILC5.2 Develop reporting mechanisms to identify barriers to pain management.
- PAILC5.3 Demonstrate review and modification of screening systems to reduce the risk of missing patients in pain. Audit recall systems to ensure they are effective.
- PAILC5.4 Demonstrate provision of resources to patients that offer realistic outcomes.
- PAILC5.5 Organise history data into coherent medical and legal reports.
- PAILC5.6 Develop systems for the patient history that accurately allow for compliance with legal requirements.
- PAILC5.7 Demonstrate ability to work in team approach in cases of chronic pain management with a variety of health professionals.
- PAILC5.8 Comply with requirements in use of Schedule 8 medications.
- PAILC5.9 Audit compliance and report of changes that are needed.

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## *Sexual health*

### Contents

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Definition	385
Curriculum in practice	385
Rationale and general practice context	386
Training outcomes of the five domains of general practice	388
Learning objectives across the GP professional life	390
<i>Medical student</i>	390
<i>Prevocational doctor</i>	391
<i>Vocational registrar</i>	393
<i>Continuing professional development</i>	394
References	395

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## Definition

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The general practice management of sexual health covers physical, emotional, mental and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. According to the World Health Organization working definition, for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.<sup>1,2</sup>

As community based health practitioners, general practitioners are vital to the maintenance of individual sexual health.

## Curriculum in practice

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Typical cases that illustrate how the sexual health curriculum applies to general practice include:

- Luci was at a wedding last weekend and drank far more than usual, perhaps in excess of 15 standard drinks of mixed spirits and champagne. It was a warm night and several of the guests then wandered down to the beach with a couple of bottles of champagne. She comes to see you for something to settle her stomach but also for the 'morning after' pill as she has had unprotected intercourse. What is your management? Three days later Luci has developed a slight discharge and lower abdominal pain. A pelvic examination finds extreme adnexal tenderness and cervical excitation. What organism is most likely and what treatment should you use?
- Carol and her partner Kate have been in a relationship for 8 months and are contemplating moving in together. Carol has a long history of depression and self harm following a brief, previous relationship that was troubled by intimate partner abuse. She has been much happier since meeting Kate. The two share a love of hiking and spend their weekends bushwalking in the local national park. Carol is worried that once they live together it will be harder to keep her sexuality a secret and wants advice on how to raise the subject with her elderly parents. She is also worried that she may lose her job at the private school where she works, which has an exemption from anti-discrimination laws. In reviewing her record, you also realise Carol has missed several appointments and is well overdue for a Pap test.

## Rationale and general practice context

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Sexuality is a basic human attribute and, as such, is a vital part of human health and wellbeing. According to the World Health Organization working definition<sup>1</sup>:

‘Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors’.

Attending to sexual health and its problems is a basic task of primary healthcare and a core part of general practice in Australia.

Sexual health presentations are common in Australian general practice. According to BEACH activity data, 5.1 out of every 100 patient encounters in general practice were for issues regarding the female genital tract (including Pap tests/check ups and menstrual problems), 3.7 out of 100 encounters were for pregnancy and family planning issues (including oral contraception and pre- and postnatal check ups), 2.8 out of 100 encounters were urological, and 1.4 out of 100 encounters were for the male genital system.<sup>3</sup> This does not include encounters for relationship counselling or other sexual health concerns.

Unsafe sex was estimated to cause 0.6% of the burden of disease in Australia in 2003<sup>4</sup> and the rates of sexually transmissible infections (STIs) continue to rise, especially in young people.<sup>5</sup> Sexual contact can transmit infections such as chlamydia, herpes simplex, human papilloma virus, hepatitis B, gonorrhoea, human immunodeficiency virus (HIV) and syphilis. Sexual activity has also been associated with an increased risk for specific cancers such as cervical and anal cancer.

While in recent times sexual health services in Western countries have been provided by sexual health centres, family planning clinics and other facilities, there has been a global trend to integrate sexual health services into primary care.<sup>6</sup> This aims to improve antenatal, perinatal, postpartum and newborn care; provide high quality services for family planning, including infertility services; eliminate unsafe abortion; combat STIs including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promote sexual health.

Due to the diverse nature of sexual practices, clinicians also need to be comfortable with discussing sex with a wide range of people including those of different ages, gender (male, female, transgender), sexual preference, culturally and linguistically diverse backgrounds, and people with disabilities.

The Australian Study of Health and Relationships (ASHR), in a population based sample of males and females aged 16–59 years, indicated that over 7% of women and 6% of men had had sexual experiences with people of the same sex. Approximately 90% of women and 95% of men indicated that they were exclusively attracted to the opposite sex. Males who identified themselves as homosexual reported a higher number of lifetime sexual partners than lesbians or heterosexuals respectively.<sup>7,8</sup>

In addition, the ASHR<sup>8</sup> indicated that the median age of reported first intercourse was 16 years of age. About 40% of males and one-quarter of females reported having had intercourse when they were below the age of 16 years, and so GPs must be able to manage sexual health concerns in young people where risks of unplanned pregnancy and STIs are high. Issues of nonconsensual sexual activity can also emerge at this time. General practitioners should be able to elicit this history and be aware of available support services and resources.

Sexual health in general practice also involves a working knowledge of legislative public health requirements of STIs and mandatory reporting. This includes a working knowledge of disease and partner notification.

## Related curriculum areas

Refer also to the curriculum statements:

- *Women's health*
- *Men's health*
- *Children and young people's health*
- *Multicultural health.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- SEHT1.1 Communicate effectively when talking about sex and sexual health, and display confidence with language and cultural sensitivity.
- SEHT1.2 Take an adequate sexual history in a nonjudgmental manner from various patient groups, including young people, people in same-sex relationships, older patients, people from culturally and linguistically diverse backgrounds, people with disabilities, injecting drug users and sex workers.
- SEHT1.3 Counsel on sexual health issues appropriate to the level of training including normal sexual activity, sexual aging, contraception, safer sex education, sexual rights, sexual diversity, contact tracing, gender sexual assault and abuse and sexual dysfunction.
- SEHT1.4 Explain to patients the importance of taking a sexual history as part of general healthcare.
- SEHT1.5 Provide competent pretest counselling and education for all STIs, in particular for HIV and hepatitis C.

## 2. Applied professional knowledge and skills

- SEHT2.1 Incorporate sexual history taking into the general medical history, including recognising clinical presentations of potentially high sexual health morbidity and mortality.
- SEHT2.2 Assess the competency of young people in making their own health decisions regarding their sexual health, including contraception.
- SEHT2.3 Perform appropriate genital examinations in a sensitive manner, recognising common normal variants and being respectful of cultural concerns.
- SEHT2.4 Understand developmental sexuality including the physical, emotional and social changes of puberty in girls and boys.
- SEHT2.5 Understand the psychology relating to sexuality and management of sexual abuse and violence.
- SEHT2.6 Understand STIs from bacterial/viral/fungal/protozoal infections including their epidemiology, basic microbiology and signs and symptoms of disease.
- SEHT2.7 Understand sexual health pathology testing, results, interpretation and principles and regional/jurisdictional knowledge of contact tracing requirements.
- SEHT2.8 Know sexual health treatments and test of cure or test of re-infection (when applicable).
- SEHT2.9 Know cervical screening and management guidelines.
- SEHT2.10 Know contraception including pharmacology, use, cost effectiveness, accessibility and patient concordance issues for both genders.
- SEHT2.11 Know genital dermatology and common gynaecological/urological problems.
- SEHT2.12 Understand sexual dysfunction as a common issue and have the ability to discuss this with patients.

## 3. Population health and the context of general practice

- SEHT3.1 Know the prevalence of common STIs such as human papilloma virus, herpes simplex virus and chlamydia and how to access local and national information on these infections.

- SEHT3.2 Be aware of changing incidences of STIs within certain population groups, eg. chlamydia in people under 25 years of age, STIs in men who have sex with men, infections acquired overseas and in the indigenous population.
- SEHT3.3 Provide opportunistic STI testing to patients at risk, eg. chlamydia testing for people under 25 years of age and those who have recently changed sexual partners, in accordance with RACGP preventive screening guidelines.
- SEHT3.4 Understand the key concepts of working with the Aboriginal community to promote indigenous sexual health.
- SEHT3.5 Understand the GP's, or other health practitioner's, role in contact tracing and follow up after an STI diagnosis.
- SEHT3.6 Promote safer sex practices including condom use when appropriate, to both young people and to adults with a recent change in sexual partner.
- SEHT3.7 Be aware that sexual dysfunction can be caused by physical and psychological conditions and is a common adverse effect of frequently prescribed medications, and be able to discuss this with patients.
- SEHT3.8 Appreciate the prevalence of sexual assault and abuse within the community and be aware of how this affects your own patient population.

#### 4. Professional and ethical role

- SEHT4.1 Understand the heightened concerns for confidentiality with regard to sexual healthcare, eg. a person at high risk of HIV may prefer to have testing done within a facility that allows coded testing, such as a sexual health centre.
- SEHT4.2 Maintain confidentiality of adolescent patients seeking sexual health and other advice as limited by duty of care.
- SEHT4.3 Establish and maintain professional boundaries.
- SEHT4.4 Work effectively with local networks to support complete sexual healthcare including sexual health clinics, family planning centres and viral hepatitis clinics.

#### 5. Organisational and legal dimensions

- SEHT5.1 Understand and comply with legal requirements with regards to HIV pretest counselling and notification of results according to the stage of training and the legal jurisdiction where the clinician practises.
- SEHT5.2 Understand the medical practitioner's and the patient's role in contact tracing, according to the stage of training and the legal jurisdiction where the clinician practises. Be aware of notification requirements and procedures and compliance with these.
- SEHT5.3 Be able to coordinate contact tracing and notification using local services acceptable to the patient, noting your legal obligations according to the stage of training and the legal jurisdiction where the clinician practises.
- SEHT5.4 Understand and comply with legal issues surrounding termination of pregnancy, according to the stage of training and the legal jurisdiction where the clinician practises.
- SEHT5.5 Understand and comply with issues relating to sexual assault, according to the stage of training and the legal jurisdiction where the clinician practises.
- SEHT5.6 Understand legal issues surrounding treatment of minors, age of consent and notification of young people at risk of harm, according to the stage of training and the legal jurisdiction where the clinician practises.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- SEHLM1.1 Describe the role of tolerance and acceptance of difference and how this affects communication skills.
- SEHLM1.2 Demonstrate how to take a sexual history as part of a medical history, according to level of training.

### 2. Applied professional knowledge and skills

- SEHLM2.1 Outline the range of normal sexual activity, fertility control and genital infection control.
- SEHLM2.2 Demonstrate appropriate confident and respectful clinical examination skills.
- SEHLM2.3 Describe the clinical investigations/tests available for the investigation of genital infection, specifically STIs.

### 3. Population health and the context of general practice

- SEHLM3.1 Describe the factors influencing the transmission and impact of STIs using the basic sciences of microbiology, anatomy, pathology, pharmacology and psychology.
- SEHLM3.2 Describe the principles and importance of education and contact tracing in patient care.
- SEHLM3.3 Describe the public health issues related to the management of STIs, both in Australia and overseas.

### 4. Professional and ethical role

- SEHLM4.1 Reflect on own personal knowledge and beliefs regarding sexuality, culture and health, and be aware of how these beliefs have the potential to affect sexual health management.
- SEHLM4.2 Demonstrate a developing understanding of ethical practice, confidentiality issues and the requirements for notification of certain STIs.

### 5. Organisational and legal dimensions

- SEHLM5.1 Describe the legal requirements regarding disease notification and laws relating to discrimination that apply to people with HIV and other infections.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- SEHLP1.1 Demonstrate the ability to take an appropriate sexual history.
- SEHLP1.2 Demonstrate developing confidence in approaching discussion of sexuality/sexual problems/sexual assault.
- SEHLP1.3 Demonstrate developing confidence in talking about sexual issues and using language that specifically relates to a range of sexual activities and practices.
- SEHLP1.4 Demonstrate the ability to provide accurate safer sex information and to understand the barriers to safer sex practice.

### 2. Applied professional knowledge and skills

- SEHLP2.1 Demonstrate the ability to confidently examine patients with STIs.
- SEHLP2.2 Describe the range, epidemiology and prevalence of STIs commonly encountered, or infrequently encountered but dangerous to miss, in the general Australian community.
- SEHLP2.3 Describe the appropriate investigations for STIs.
- SEHLP2.4 Describe the range of management options for the treatment of common STIs.
- SEHLP2.5 Demonstrate knowledge of the interface between sexual and reproductive health and how sexual behaviour may influence contraceptive options.

### 3. Population health and the context of general practice

- SEHLP3.1 Describe the differences in the patterns of STIs and the specific health issues that may exist within different groups in the Australian community, eg. men who have sex with men, Aboriginal and Torres Strait Islander people, recently arrived refugees, youth, the culturally and linguistically diverse, women who have sex with women, sex workers and intravenous drug users.
- SEHLP3.2 Describe the extent of HIV in Australian community with regard to case identification and management within a hospital environment.

### 4. Professional and ethical role

- SEHLP4.1 Demonstrate developing ability to handle complex medical and psychosocial issues in a nonjudgmental way relating to sexual health.
- SEHLP4.2 Demonstrate increasing awareness of cultural, age related and gender differences in the approach and reaction to STIs.
- SEHLP4.3 Reflect on the diversity of sexual experience based on personal experience and undergraduate training, which has encouraged an open approach to such diversity through patient and peer contact and appropriate teaching.

## 5. Organisational and legal dimensions

- SEHLP5.1 Identify resource groups and individuals who can assist and advise with the management of sexual health issues.
- SEHLP5.2 Describe ethical clinical practice, notification, public health acts and contact tracing with regard to sexual health.
- SEHLP5.3 Describe mandatory reporting regulations with respect to STIs and their implementation.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- SEHLV1.1 Demonstrate openness to diversity through patient and peer contact and confidence in basic clinical and interpersonal skills in the provision of sexual healthcare.

### 2. Applied professional knowledge and skills

- SEHLV2.1 Demonstrate the ability to assess, examine and investigate patients presenting with sexual health problems, including possible infection.

### 3. Population health and the context of general practice

- SEHLV3.1 Describe the principles and practices of contact tracing and how they apply to the community that the practitioner is working in.
- SEHLV3.2 Demonstrate the ability to function independently in community practice with reference to appropriate sexual health screening and public health measures.

### 4. Professional and ethical role

- SEHLV4.1 Demonstrate continual development and awareness of how personal attitudes and experiences may affect clinical practice.
- SEHLV4.2 Demonstrate the ability to practise in a manner in which confidentiality is maintained within the legal obligations, especially of contact tracing.
- SEHLV4.3 Describe the ethical implications of sexual health issues.

### 5. Organisational and legal dimensions

- SEHLV5.1 Describe the legal implications of sexual health issues.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- SEHLC1.1 Demonstrate the ability to raise the issue of intimate partner violence or unwanted sexual experience in the context of routine sexual healthcare enquiries and develop a planned approach to the management of disclosure.

### 2. Applied professional knowledge and skills

- SEHLC2.1 Demonstrate commitment to continue exploring the field of sexual health and the challenges within your own practice.
- SEHLC2.2 Demonstrate commitment to providing best practice in sexual healthcare provision.

### 3. Population health and the context of general practice

- SEHLC3.1 Describe and demonstrate the ability to manage the particular sexual health needs of various subpopulations at risk, eg. Aboriginal and Torres Strait Islander people, young people, gay, lesbian, bisexual, transgender, intersex patients, patients from culturally and linguistically diverse backgrounds, and people with disabilities.

### 4. Professional and ethical role

- SEHLC4.1 Reflect and act on clinician professional development needs in sexual health medicine including quality assurance and continuing professional development activities.

### 5. Organisational and legal dimensions

- SEHLC5.1 Demonstrate a willingness to tailor practice to encourage clients from diverse backgrounds to attend for sexual health services.
- SEHLC5.2 Regularly review clinical practice in relation to the major issues in sexual healthcare provision and changes that may occur within own community (eg. chlamydia in young people).

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## *Sports medicine*

### Contents

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Definition	399
Curriculum in practice	399
Rationale and general practice context	400
Training outcomes of the five domains of general practice	401
Learning objectives across the GP professional life	403
<i>Medical student</i>	403
<i>Prevocational doctor</i>	404
<i>Vocational registrar</i>	406
<i>Continuing professional development</i>	407
References	408

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## Definition

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Sports medicine encompasses the range of study into the medicine of exercising people. This involves the assessment and management of sporting people, the prevention of injury through the application of sports science knowledge and the application of exercise physiology knowledge to our community at large.

The core elements for consideration are knowledge of:

- the prevention and management of common sport and exercise related injuries
- the role of inactivity in the aetiology of chronic disease, and
- exercise as a therapeutic tool.

## Curriculum in practice

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The following case illustrates how the sports medicine curriculum applies to general practice:

- Jemma, a slightly overweight 12 year old girl, joined a netball team to become fit. Almost immediately she began to experience anterior knee pain. The pain is worse with running and also with walking down stairs. Sometimes when she has been sitting still for a time the knee feels unstable when she first stands up, but she does not have significant swelling.

## Rationale and general practice context

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Competitive sport holds a prominent place in the Australian psyche and recreational physical activity is a key strategy in promoting healthy lifestyles and preventive medicine. Although many patients first present with an acute sporting injury to hospital emergency departments,<sup>1</sup> general practitioners provide a comparable or even higher number of sports medicine related services than hospitals.<sup>2</sup> Therefore the assessment and management of sporting injuries is a significant part of the workload of general practice.

The study and practice of sports medicine is a rapidly growing area of medicine, and athletes and recreational sports participants now expect a high standard of care which has had a direct impact on the practice of sports medicine by GPs.

Patients present for a wide range of advice related to sport and exercise. The study of sports medicine also entails an understanding of the relevance of exercise to the general population and the aging Australian community. This includes the benefits and risks of exercise and the important role of exercise in the management of many chronic diseases.

General practitioners are well situated to provide holistic care in these areas,<sup>3</sup> helping to avoid fragmentation of management.

### Related curriculum areas

Refer also to the curriculum statements:

- *Musculoskeletal medicine*
- *Occupational medicine*.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- SPOT1.1** Listen and understand the needs of the sports medicine patient. Athletes may have different expectations of outcomes compared to other recreational sports participants or someone using exercise for chronic disease management.
- SPOT1.2** Use empathy and supportive strategies to encourage the patient to show their emotions and express their needs and fears, for examples athletes with injuries will often have fear of their injury and develop an early grief reaction when seen for treatment. Patients with diabetes and obesity may be fearful of an exercise program, with different types of fears.
- SPOT1.3** Develop a partnership with the patient so that issues surrounding the injury and exercise can be assessed and explored more easily. It may be that the athlete has unrealistic expectations of their speed of recovery or has an eating disorder; or that the diabetic may have an underlying depressive illness.

## 2. Applied professional knowledge and skills

- SPOT2.1** Know the basis of musculoskeletal medicine, physiology and pathology that needs to be applied in an efficient and productive way to manage sports related conditions.
- SPOT2.2** Understand applied anatomy and surface anatomy to be able to assess sports injuries quickly and thoroughly.
- SPOT2.3** Know the concepts of injury causation (trauma versus repetitive microtrauma).
- SPOT2.4** Know the difference between types of exercise and their effects on the body, the beneficial effects of exercise on the body (both normal body and diseased), and have a basic understanding of potential risks of exercise.
- SPOT2.5** Know the more common sporting injuries and conditions that need to be excluded for proper and safe practise of sports medicine.
- SPOT2.6** Be able to take a thorough history and apply a specific examination to elicit the information needed to make a proper diagnosis.
- SPOT2.7** Understand the available investigations and how and when to apply them.
- SPOT2.8** Have the appropriate skills in directing treatment to the athlete or injured patient which may involve other healthcare professionals as part of co-ordinated care.

## 3. Population health and the context of general practice

- SPOT3.1** Apply opportunistic injury prevention, for example, the assessment of obvious biomechanical abnormalities in young athletes to the expected level of knowledge of the clinician.
- SPOT3.2** Apply exercise physiology concepts to the general community and specific targeted groups including: impaired glucose tolerance/metabolic syndrome; type 2 diabetes; obesity and hypertension; prevention of ischaemic heart disease; fall prevention in the elderly; and mental health, including depression, anxiety and premenstrual dysphoria syndrome.

## 4. Professional and ethical role

- SPOT4.1 Understand the ethical issues surrounding duty of care toward athletes and how this may have the potential to conflict with pressures from coaches and sporting clubs.
- SPOT4.2 Have a working knowledge of drugs in sport requirements to meet legal and ethical responsibilities.

## 5. Organisational and legal dimensions

- SPOT5.1 Recognise that sports medicine workplaces may involve sporting field/arena attendance and issues related to safety and security.
- SPOT5.2 Ensure appropriate equipment is available for any eventuality when treating in a sporting field/arena and ensure compliance with guidelines for existing minimum on field equipment.
- SPOT5.3 Ensure practice security, sound record keeping, confidentiality and safe handling practices when providing care in a sporting field/arena.
- SPOT5.4 Ensure that the practice and practitioner comply with occupational health and safety guidelines when assessing and managing injured athletes and other patients, including universal precautions and safe management of sharps.
- SPOT5.5 Know the legal requirements for the safe management of athletes including resolving the potential conflict of interest when the duty of care is to the athlete, when a sporting club may employ the GP and a knowledge and application of drugs in sport guidelines.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- SPOLM1.1 Demonstrate how to take a history including the onset, mode of injury and consequent symptoms that relate to the injury.
- SPOLM1.2 Describe how the sports medicine needs and expectations of patients may differ.
- SPOLM1.3 Describe the importance of developing a partnership with the patient in sports medicine.

### 2. Applied professional knowledge and skills

- SPOLM2.1 Demonstrate good knowledge of anatomy and surface anatomy.
- SPOLM2.2 Describe the basic concepts of injury type and their differences.
- SPOLM2.3 Demonstrate a basic physical examination on a patient presenting with a sport related injury.
- SPOLM2.4 Demonstrate the ability to suggest appropriate initial investigations, a provisional diagnosis and an early management plan.
- SPOLM2.5 Describe the basic clinical management of more common sporting injuries.
- SPOLM2.6 Describe the basic concepts and interpretation of imaging modalities.
- SPOLM2.7 Describe the basic concepts of therapeutics as they pertain to sports medicine (eg. pharmacology, manual therapies and injection therapies).
- SPOLM2.8 Outline the principles of the physiology of exercise including hydration and nutrition.

### 3. Population health and the context of general practice

- SPOLM3.1 Outline key concepts in injury prevention.
- SPOLM3.2 Describe the population based benefits of exercise, both for the general population and for specific subgroups.
- SPOLM3.3 Describe the broad based public health effects on well people and people with illness with respect to aerobic exercise versus resistance exercise. needs.

### 4. Professional and ethical role

- SPOLM4.1 Describe ethical issues surrounding duty of care toward athletes and potential to conflict with other pressures (eg. internal pressures self imposed by the athlete and external pressures, eg. coaches and clubs).
- SPOLM4.2 Outline ethical principles of the use of drugs in sport.

### 5. Organisational and legal dimensions

- SPOLM5.1 Describe the concepts of occupational health and safety issues as they pertain to the health and sporting sectors.
- SPOLM5.2 Describe the issues of duty of care and legal responsibility issues involved in on-field care.
- SPOLM5.3 Outline legislative requirements in relation to sports and exercise (eg. drugs in sport).

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- SPOLP1.1 Demonstrate how to take a thorough history and examination to elicit the information needed make a proper diagnosis in the hospital setting, especially in the emergency department.
- SPOLP1.2 Demonstrate how to elicit a history that is specific to the type of injury, whether acute, subacute or chronic in nature and mode of injury.
- SPOLP1.3 Describe the use of empathy and supportive strategies to encourage the patient to show their emotions and express their needs and fears.
- SPOLP1.4 Demonstrate how to communicate realistic expectations on recovery to patients.
- SPOLP1.5 Describe how to ensure clear communication of referral and follow up procedures.

### 2. Applied professional knowledge and skills

- SPOLP2.1 Demonstrate the application of the concepts of exercise physiology and the role of exercise in disease modification and prevention.
- SPOLP2.2 Demonstrate an understanding of applied anatomy and surface anatomy which is very important to assess sports injuries quickly and thoroughly.
- SPOLP2.3 Describe concepts of injury causation (trauma versus repetitive microtrauma) and the natural history of sports related injuries.
- SPOLP2.4 Describe the management of the more common sporting injuries and conditions.
- SPOLP2.5 Describe important conditions that need to be excluded for proper and safe practice of sports medicine.
- SPOLP2.6 Understand the available investigations and how and when to apply them.

### 3. Population health and the context of general practice

- SPOLP3.1 Demonstrate an ability to counsel for promoting exercise and injury prevention.
- SPOLP3.2 Identify subgroups that benefit from exercise and the levels of exercise appropriate to each group.

### 4. Professional and ethical role

- SPOLP4.1 Describe the roles of health professionals managing sports related injuries (eg. medical specialists and physiotherapists).
- SPOLP4.2 Demonstrate a working knowledge of the importance of duty of care issues in sports medicine.

## 5. Organisational and legal dimensions

- SPOLP5.1 Demonstrate a knowledge of potential sports medical, occupational health and safety related issues.
- SPOLP5.2 Describe processes and procedures in place to ensure that sports related injuries are appropriately referred when indicated.
- SPOLP5.3 Demonstrate compliance with any legislative requirements regarding sports medicine.

# Learning objectives across the GP professional life —

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- SPOLV1.1 Demonstrate advanced history taking skills including the meaning of the injury to the patient.
- SPOLV1.2 Discuss the importance of empathy and a partnership approach to treatment and management.

### 2. Applied professional knowledge and skills

- SPOLV2.1 Demonstrate good knowledge of applied anatomy, applied physiology and applied pathology.
- SPOLV2.2 Demonstrate the ability to accurately take a history and examine and order appropriate investigations.
- SPOLV2.3 Demonstrate an ability to accurately diagnose injuries and prescribe exercise where appropriate.
- SPOLV2.4 List differential diagnoses that pertain to an injury to include important other injuries.

### 3. Population health and the context of general practice

- SPOLV3.1 Describe the role of inactivity in the aetiology of chronic illnesses and the role of exercise in prevention and management of these conditions.
- SPOLV3.2 Demonstrate opportunistic injury prevention.
- SPOLV3.3 Describe how to detect and treat biomechanical problems and, thereby, prevent sporting injury to the level of knowledge of the clinician.
- SPOLV3.4 Describe the differing types of exercise and which subpopulations exercise types are suitable for and when to prescribe exercise, including the special requirements of elite or professional athletes.

### 4. Professional and ethical role

- SPOLV4.1 Demonstrate use of a team approach to managing sports related injuries.
- SPOLV4.2 Demonstrate compliance with the concept of duty of care and potential for conflict.
- SPOLV4.3 Demonstrate use of drugs in sport practice requirements and understand the consequences of not doing this.

### 5. Organisational and legal dimensions

- SPOLV5.1 Outline a practice approach to sports injury management including the involvement of allied health practitioners (eg. physiotherapy, podiatry, dietician, psychologist), as well as appropriate referral to doctors with special expertise.
- SPOLV5.2 Describe strategies in place for reviewing and assessing outcomes of treatment.
- SPOLV5.3 Describe practice processes in place to safeguard occupational health and safety and meeting legislative drugs in sport requirements.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- SPOLC1.1 Reflect on, and update, communication skills necessary for managing sports related injuries, including more specific questioning about mode of injury, consequences of the injury to the patient, as well as the meaning of the injury to the patient's future sporting activity.

### 2. Applied professional knowledge and skills

- SPOLC2.1 Demonstrate the long term educational need to maintain an up-to-date knowledge of sports injury and exercise physiology.

### 3. Population health and the context of general practice

- SPOLC3.1 Demonstrate the long term educational need to maintain an up-to-date knowledge of exercise concepts and the ability to prescribe the correct type of exercise is important at this level.
- SPOLC3.1 Demonstrate the long term educational need to maintain an up-to-date knowledge of injury prevention concepts.

### 4. Professional and ethical role

- SPOLC4.1 Consider further education concerning sports medicine and exercise prescription as part of ongoing professional development and education.
- SPOLC4.2 Consider specific further education if developing a special interest in sports medicine through short courses, seminars and specific postgraduate courses, mainly run through universities.
- SPOLC4.3 Demonstrate maintenance of an up-to-date knowledge of duty of care issues and drugs in sport requirements
- SPOLC4.4 Consider teaching sports medicine related issues to training GPs and other doctors.
- SPOLC4.5 Demonstrate a good working knowledge of exercise prescription and its importance to public health and future disease prevention

### 5. Organisational and legal dimensions

- SPOLC5.1 Demonstrate maintenance and compliance with an up-to-date knowledge of legal and ethical issues relating to sports medicine, including changes in legislation, changes in banned substances and changes in duty of care issues.

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## *Critical thinking and research*

### **Contents**

---

Definition	411
Curriculum in practice	411
Rationale and general practice context	412
Training outcomes of the five domains of general practice	415
Learning objectives across the GP professional life	417
<i>Medical student</i>	417
<i>Prevocational doctor</i>	418
<i>Vocational registrar</i>	419
<i>Continuing professional development</i>	421
References	422

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## Definition

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Critical thinking is a core competency for evidence based general practice<sup>1</sup> and an essential precursor to research. It is also essential for evaluating and understanding the implications of research for clinical practice.

Critical thinking involves a continual questioning of the assumptions underpinning all aspects of a general practitioner's professional life and consists of:

- critical appraisal — the process of assessing and interpreting evidence by systematically considering its validity, results and relevance<sup>2</sup> — necessary for the evaluation of research results and their application to clinical practice
- critical evaluation of the context of general practice
- critical introspection to gain an understanding of personal knowledge, experience and values that influence the way medicine is practised.<sup>3</sup>

General practice and primary care research have been described as 'the missing link in the development of high quality, evidence based healthcare for populations'.<sup>1</sup>

Using a broad, conceptual definition, the research process can be summarised as deliberately asking questions within the framework of existing knowledge and seeking answers following a systematic process which includes:

- obtaining appropriate information in an ethical, transparent and reproducible manner
- appropriately analysing the information
- drawing conclusions on the basis of the validity and reliability of the information and meaning of the results, and comparing these results to other studies
- disseminating the implications widely, including to those who may effect change.

The spectrum of research activities is wide and can include evaluation studies, intervention studies, clinical audits, large scale multicentre clinical trials, and patient satisfaction studies. Research activities can use qualitative or quantitative research methods, or a combination of both. However, each of these activities must be conducted according to the established 'rules' of the research process in order to be considered research.

## Curriculum in practice

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The following case illustrates how the critical thinking and research curriculum applies to general practice:

- There has been a local outbreak of pertussis and, sadly, a number of children from your practice have been admitted to hospital; one baby has died. In reviewing local data pertaining to children with incomplete vaccinations, the number of children with exemptions from vaccination appears to be higher than expected. There are concerns that the outbreak may relate to parental anxieties triggered by a local anti-vaccination lobby group. Research confirms incomplete vaccination may be due to parents disagreeing with immunisation rather than medical contraindications or issues of access. This results in the public health unit developing a public education strategy.

## Rationale and general practice context

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### GPs as critical thinkers

Critical thinking and research promote essential lifelong learning skills throughout the general practitioner's working life. Both enable the GP to provide the best possible patient care by developing the GP's ability to:

- identify the many important clinical and research questions arising in their everyday clinical practice
- critically appraise research papers to confidently and accurately answer these questions
- apply this research evidence to patients and communities.

To critically appraise a research paper, clinicians must have sufficient knowledge and understanding of a range of research methods, which can best be gained by undertaking formal and structured training in research methods.

Critical appraisal skills are also important in assisting clinicians to implement or participate in research projects. Such clinicians need opportunities to do research, as well as to access appropriate mentoring and support, particularly through linking with research organisations or academic institutions including university departments of general practice.

### GPs as researchers

General practice research aims to solve the problems that arise within the specific context of general practice. The context and the way in which the research is conducted characterises general practice research rather than the nature of the problem investigated.<sup>4</sup>

General practitioners need to be researchers in order to pose relevant clinical questions for research, understand the complexity of the general practice context and therefore be able to facilitate research within this context.

General practice research must be conducted within general practice to provide answers to the specific and unique problems that arise within this context,<sup>5-9</sup> in particular because:

- the general practice context is different from specialist and hospital contexts, especially regarding the holistic treatment of people with multimorbidities and undifferentiated illness within the context of uncertainty
- diagnostic delays lead to poorer outcomes for patients
- GPs play a pivotal role as gatekeepers to the health system and the absence of research evidence can lead to over-investigation, inappropriate treatment and diagnostic delay through inappropriate referrals
- decision about medication is significant and many patients take medication prescribed in primary care all their lives.<sup>1</sup>
- as a person-focused, applied discipline, general practice research concentrates on applied research that goes beyond the biomedical aspects of illness and incorporates issues that address psychosocial aspects of wellbeing,<sup>10</sup> which inherently requires multidisciplinary approaches and multiple methodologies.<sup>11</sup>

### Why critical thinking and research are needed in general practice

Critical thinking and research improve patient care in general practice. Research evidence is the fundamental way in which routine clinical practice is improved. Critical thinking and reflection are essential precursors for the incorporation of research evidence into practice. Training in these skills also cultivates an interest in undertaking much needed general practice research.

General practice research productivity is far lower than that of other medical disciplines, with an approximate publication rate of three publications per 1000 GPs per year compared to about 160 publications per 1000 physicians and 68 per 1000 surgeons.<sup>12</sup>

## Levels of engagement in critical thinking and research

There are varying levels of engagement in critical thinking and research in general practice. Users and participants, as well as leaders, should be actively involved (*Figure 1*) at the highest order within each level of involvement.

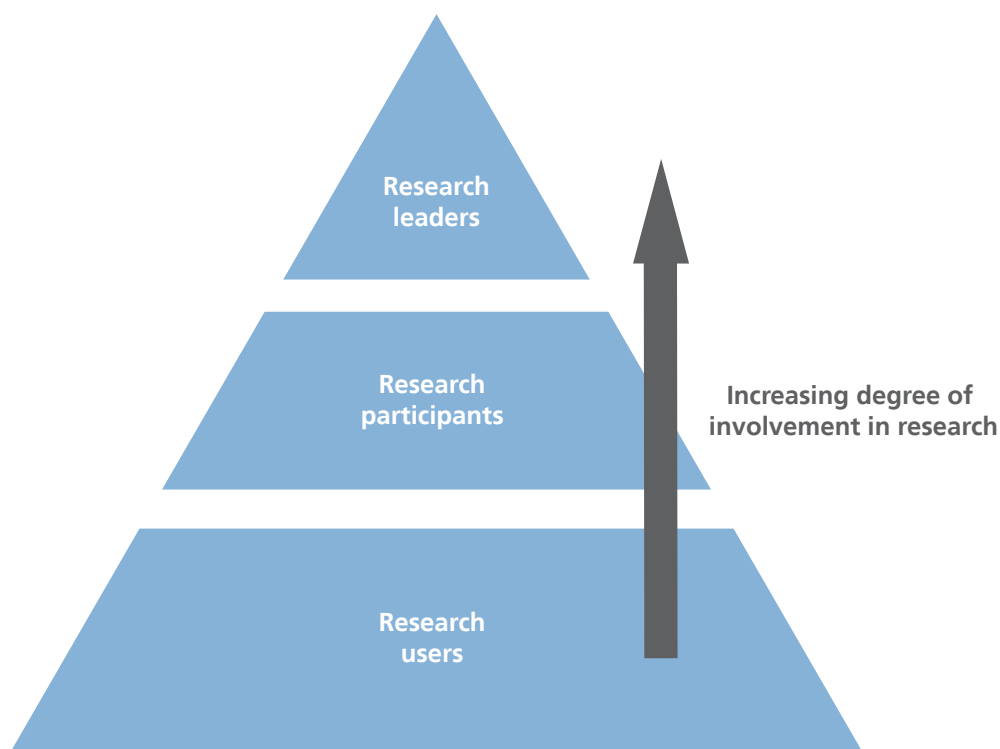


Figure 1. The levels of research engagement.

Adapted from 'Glasziou's triangle'<sup>13</sup> and reproduced from Australian Family Physician with permission

Research leaders are those who conceptualise, design, find funding for, conduct and publish research.

Research participants are those who participate in general practice research. Highest order participants are intellectually engaged in the research, understand and feel aligned to its purpose, could describe the project to a third party, and are interested in the results. Usually they are sufficiently part of the research to earn authorship. Lower order participants may just recruit patients for research projects conceptualised and instigated by others such as universities, specialist colleagues or pharmaceutical companies. Involvement in research at medical school and during general practice training is associated with increased ability and confidence in interpreting research findings in subsequent clinical practice, in addition to increased subsequent involvement in general practice research.<sup>5,14,15</sup>

All GPs are research users, using research evidence (the base of the triangle) as clinical practice within general practice, and are informed by research from a myriad of health related fields ranging from biochemical to macrosocial levels. This research evidence is accessed in a range of forms from a wide number of sources such as journals, medical newspapers, formal educational activities and discussions with their colleagues,<sup>18</sup> and can lead to changes in practice. However, the critical thinkers consciously seek the best available research evidence, to appraise and combine with clinical experience and patient values to inform their clinical decision making (the principles of evidence based medicine [EBM]). The ability to critically appraise a research paper is a minimum entry level skill set for general practice.

Increasing the numbers of GPs actively using research evidence (practising EBM) encourages critical enquiry within the discipline and highlights gaps in the evidence. Some GPs will want to address these gaps through leading or participating in research.

## Specific research needs of general practice

The specific needs of general practice research impact on all GPs, regardless of their level of involvement in general practice research.

General practice has specific research needs with a high degree of contextual complexity (a broad range of relatively unevolved signs and symptoms, presented within the patient's psychological and social setting) compared with the technical complexity of the medical specialties (a narrower range of defined symptoms across single organ systems, more severe illnesses and limited reference to the patient's social context).

There are gaps in the evidence that GPs need for making decisions, limiting the ability to provide the highest quality care. These gaps are:

- basic science: the lack of biomedical and psychosocial evidence. The gap in biomedical science is exemplified by the lack of knowledge about the pathophysiology and natural history of many of the diseases commonly seen in general practice. The limited understanding of help seeking behaviour is an example of a psychosocial gap (eg. why do some patients with upper respiratory tract infections present to their GP, while others with the same symptoms self medicate or take no action?)
- effectiveness: the lack of evidence demonstrating both the effectiveness and cost effectiveness of interventions routinely used in general practice (diagnosis, treatment and service delivery)
- applicability: a lack of 'translation research' to ensure that evidence generated in nonprimary care settings is applicable in general practice
- implementation: the gap between identifying effective care and who should receive it, and what occurs in routine general practice.

General practice research also focuses on the taxonomy of general practice itself. A better knowledge of the processes employed in general practice and successful models of healthcare delivery will support more effective, cost efficient and sustainable practice.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- CTRT1.1 Communicate the evidence for management, diagnosis or screening to patients in a manner that is both understandable to the patient and is patient centred.
- CTRT1.2 Involve the patient in the evidence based decision making process about their health and acknowledge the informed patient's right to choose to accept or decline new interventions based on research evidence.
- CTRT1.3 Be aware that beliefs and values, in doctor and patient, influence the interpretation of research results in support of potentially divergent views.

## 2. Applied professional knowledge and skills

- CTRT2.1 Have well developed skills in reflective practice and critical thinking in order to identify and formulate questions as they arise in clinical practice.
- CTRT2.2 Have sound skills in evidence gathering (eg. where to find resources, how to search databases, internet searching skills).
- CTRT2.3 Have sound skills in critical appraisal of different types of evidence sources.
- CTRT2.4 Apply the hierarchy of evidence available for clinical decision making.
- CTRT2.5 Applying research evidence from clinical trials to individual patients within their unique context and comorbidities.
- CTRT2.6 Be able to share and disseminate the results of research or critical evaluation and literature reviews to peers or other health professionals.
- CTRT2.7 Understand the methods and practices to evaluate, reflect on and improve clinical and nonclinical practice (eg. clinical audit, needs analysis, quality improvement cycles).
- CTRT2.8 Develop a rational approach to prescribing and investigations that includes knowledge of risk, costs and benefits of management and tests.
- CTRT2.9 Understand how research funding and publication bias can lead to a bias in evidence.

## 3. Population health and the context of general practice

- CTRT3.1 Understand the role and importance of general practice and primary care to improving population health.
- CTRT3.2 Appreciate the importance of general practice and primary care research.
- CTRT3.3 Have a basic understanding of general practice research and epidemiological methods and concepts (eg. qualitative and quantitative research methods, and concepts such as incidence, prevalence and screening).
- CTRT3.4 Understand the basic statistical techniques for describing and interpreting results of research (eg. *p* values, confidence intervals, absolute and relative risk, positive and negative predictive value, number needed to treat, sensitivity and specificity) and be able to use these terms when critically appraising research results.
- CTRT3.5 Be familiar with the essential components of the research process (eg. developing a research question, identifying appropriate methods, basic qualitative and quantitative analysis skills, drawing appropriate conclusions, summarising and disseminating results).
- CTRT3.6 Be aware of the limited generalisability of research evidence when applying evidence about screening, diagnosis and treatment to individual patients and practices with attention to the general practice setting.

## 4. Professional and ethical role

- CTRT4.1 Ensure that issues such as privacy and ethical principles are adhered to when undertaking research or quality improvement activities, and approval is obtained from an appropriate human research ethics committee as required.
- CTRT4.2 Understand the power differential in the patient-doctor relationship when performing research or quality improvement activities, and ensure that a patient's vulnerability is recognised and appropriately managed, including providing full information and obtaining informed consent.
- CTRT4.3 Think critically about issues arising both in individual clinical practice (eg. critical incidents, mistakes, patient feedback) and in the wider context of general practice (eg. population health status, medical politics).
- CTRT4.4 Be aware of your own knowledge, limitations, biases and values that influence the way one practices medicine.
- CTRT4.5 Be aware of external influences on own practice (eg. pharmaceutical companies, media) and be confident in dealing appropriately with these influences.
- CTRT4.6 Be flexible and willing to change beliefs and practice in the face of new evidence.
- CTRT4.7 Acknowledge uncertainty (to self and patients) in clinical practice, without forgoing the efforts to decrease uncertainty where feasible and necessary.
- CTRT4.8 Facilitate, where appropriate, research within one's own general practice.

## 5. Organisational and legal dimensions

- CTRT5.1 Understand the importance of, and have, the ability to continually evaluate and reflect on performance in clinical and nonclinical practice (both individually and with peers and within primary care teams) and use appropriate methods to implement and evaluate change where necessary, including in settings of quality improvement.
- CTRT5.2 Understand the ethical and legislative requirements of privacy principles when using patient information for research or quality improvement purposes.
- CTRT5.3 Have computer skills sufficient to access internet literature and to practise in a computerised general practice.
- CTRT5.4 Understand the importance of, and the need to, practise the recording of patient data on clinical software systems in a way that enables quality improvement activities and research to be reliably conducted at a later date, and to know how to use clinical software to retrieve data for quality improvement activities or research (eg. performing a database search).

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- CTRLM1.1 Describe the principles underpinning the skills required to communicate evidence for management, diagnosis or screening to patients.

### 2. Applied professional knowledge and skills

- CTRLM2.1 Outline the basic principles of clinical epidemiology, including basic statistical concepts.
- CTRLM2.2 Demonstrate skills in literature searching including the use of PubMed and Cochrane databases.
- CTRLM2.3 Outline the scientific method and the origins of medical knowledge.
- CTRLM2.4 Describe the challenges in applying research evidence to individual patients.
- CTRLM2.5 Demonstrate the beginning of skills in communicating health information to peers.

### 3. Population health and the context of general practice

- CTRLM3.1 Describe the basic statistical techniques for describing and interpreting results of research (eg. *p* values, confidence intervals, absolute and relative risk, positive and negative predictive value, number needed to treat, sensitivity and specificity) and be able to use these terms when critically appraising research results.
- CTRLM3.2 Give a basic description of population health issues in clinical epidemiology.
- CTRLM3.3 Give a basic overview of research concepts.

### 4. Professional and ethical role

- CTRLM4.1 Demonstrate development of skills in self directed learning, including reflective practice and critical thinking, to identify gaps in knowledge

### 5. Organisational and legal dimensions

- CTRLM5.1 Outline the ethical and legislative requirements of privacy principles when using patient information for research or quality improvement purposes.
- CTRLM5.2 Outline the quality improvement process.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- CTRLP1.1 Demonstrate the beginning of developing skills for communicating evidence for treatment or screening to patients.

### 2. Applied professional knowledge and skills

- CTRLP2.1 Demonstrate the ability to apply best medical evidence in patient care.
- CTRLP2.2 Detail diagnostic test characteristics, and their use in including and excluding diagnoses.
- CTRLP2.3 Demonstrate the beginning of developing skills in rational prescribing and ordering of investigations.
- CTRLP2.4 Demonstrate the use of clinical guidelines and recent evidence to guide patient care decisions.

### 3. Population health and the context of general practice

- CTRLP3.1 Demonstrate the ability to use basic statistical techniques for describing and interpreting results of research (eg. *p* values, confidence intervals, absolute and relative risk, positive and negative predictive value, number needed to treat, sensitivity and specificity) and be able to use these terms when critically appraising research results.

### 4. Professional and ethical role

- CTRLP4.1 Recognise that some patients may be involved in research or may want to be involved in research and, where appropriate, communicate and comply with the appropriate researchers.
- CTRLP4.2 Describe and analyse, using critical thinking skills, the harm caused by system errors and failure, and recognise and manage adverse events and near misses.

### 5. Organisational and legal dimensions

- CTRLP5.1 Describe processes for correctly documenting patients involved in research, where appropriate.
- CTRLP5.2 Describe and demonstrate awareness of the legislative and ethical requirements for patients participating in research.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- CTRLV1.1 Demonstrate the ability to communicate the evidence for management, diagnosis or screening to patients in a manner that is both understandable to the patient and is patient centred.
- CTRLV1.2 Demonstrate the ability to involve the patient in the decision making process about their health and acknowledge the informed patient's right to choose to accept or decline new interventions based on research evidence.
- CTRLV1.3 Describe how beliefs and values, in doctor and patient, influence the interpretation of research results in support of potentially divergent views.

### 2. Applied professional knowledge and skills

- CTRLV2.1 Demonstrate well developed skills in reflective practice and critical thinking in order to identify and formulate questions as they arise in clinical practice.
- CTRLV2.2 Demonstrate sound skills in evidence gathering (eg. where to find resources, how to search databases, internet searching skills).
- CTRLV2.3 Demonstrate sound skills in critically appraising different types of evidence sources.
- CTRLV2.4 Develop a rational approach to prescribing and investigation that includes knowledge of risk, costs and benefits of treatment and tests.
- CTRLV2.5 Outline the hierarchies of evidence available for clinical decision making.
- CTRLV2.6 Outline how research funding and publication bias can influence the evidence base of clinical practice.
- CTRLV2.6 Outline the essential components of the research process (eg. developing a research question, identifying appropriate methods, basic qualitative and quantitative analysis skills, drawing appropriate conclusions, summarising and disseminating results).
- CTRLV2.7 Demonstrate skills in applying research evidence from clinical trials to individual patients within their unique context and comorbidities.
- CTRLV2.8 Where indicated, demonstrate an ability to disseminate the results of research, or critical evaluation/literature review to peers or other health professionals.
- CTRLV2.9 Outline methods to evaluate, reflect on and improve clinical and nonclinical practice (eg. clinical audit, needs analysis, quality improvement cycles).

### 3. Population health and the context of general practice

- CTRLV3.1 Outline the role and importance of general practice and primary care to population health in Australia and internationally.
- CTRLV3.2 Understand the importance of general practice and primary care research.
- CTRLV3.3 Demonstrate a basic understanding of general practice and primary care research and epidemiological concepts and methods (eg. qualitative and quantitative research methods, and concepts such as incidence, prevalence and screening).

- CTRLV3.4** Describe basic statistical techniques for describing and interpreting results of research (eg. *p* values, confidence intervals, absolute and relative risk, positive and negative predictive value, number needed to treat, sensitivity and specificity) and be able to use these terms when critically appraising research results.
- CTRLV3.5** Describe the principles underlying generalisability of research evidence when applying evidence about screening, diagnosis and treatment to individual patients and/or practices.

## 4. Professional and ethical role

- CTRLV4.1** Demonstrate adherence to privacy and ethical principles when undertaking research or quality improvement activities, and obtain approval from an appropriate human research ethics committee.
- CTRLV4.2** Describe the power differential in the patient-doctor relationship when performing research or quality improvement activities, and ensure that a patient's vulnerability is recognised and appropriately managed, including providing full information and obtaining informed consent.
- CTRLV4.3** Demonstrate critical thinking about issues arising both in individual clinical practice (eg. critical incidents, mistakes, patient feedback) and in the wider context of general practice (eg. population health status).
- CTRLV4.4** Describe how the individual clinician is aware of personal knowledge, limitations, biases and values that may influence the way one practises medicine.
- CTRLV4.5** Demonstrate awareness of external influences on one's practice (eg. pharmaceutical companies, media) and be confident in dealing appropriately with these influences critically.
- CTRLV4.6** Demonstrate flexibility and willingness to change beliefs and practice in the face of new evidence.
- CTRLV4.7** Outline processes for acknowledging uncertainty (to self and patients) in clinical practice, without forgoing the efforts to decrease uncertainty where feasible and necessary.

## 5. Organisational and legal dimensions

- CTRLV5.1** Describe the importance of, and have, the ability to be continually evaluating and reflecting on performance in clinical and nonclinical practice (both individually and with peers and within primary care teams) and use appropriate methods to implement and evaluate change where necessary.
- CTRLV5.2** Describe and comply with the requirements of privacy principles when using patient information for research or quality improvement purposes.
- CTRLV5.3** Demonstrate the use of computer skills sufficient to access internet literature and to practise in a computerised general practice.
- CTRLV5.4** Understand the importance of, and the need to, record patient data on clinical software systems in a way that enables quality improvement activities and research to be reliably conducted at a later date, and know how to use clinical software to retrieve data for quality improvement activities or research (eg. performing a database search).

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

CTRLC1.1 Regularly review communication skills in relation to critical thinking and research.

### 2. Applied professional knowledge and skills

CTRLC2.1 Demonstrate ongoing development of skills in gathering evidence.

CTRLC2.2 Demonstrate continual refinement and development of a rational approach to prescribing and ordering investigations, which may include the use of tools such as clinical audits.

CTRLC2.3 Demonstrate continual development of skills in applying research evidence to the individual patient.

CTRLC2.4 Demonstrate competence in the use of at least one type of quality improvement measure and the use of this in practice.

### 3. Population health and the context of general practice

CTRLC3.1 Demonstrate the means to ensure balance in responsibility to individual patients and larger population health needs and constraints.

### 4. Professional and ethical role

CTRLC4.1 Demonstrate maintenance of high ethical and professional standards in the care of patients by a judicious balance of the 'science' and 'art' of medicine.

CTRLC4.2 Demonstrate maintenance of an up-to-date knowledge base by a combination of periodic knowledge updates and needs driven learning strategies. The latter requires 'information mastery' and evidence based practice skills.

### 5. Organisational and legal dimensions

CTRLC5.1 Demonstrate the adoption of new skills and technologies that assist best medical practice (eg. updating computer and internet skills and equipment).

CTRLC5.2 Conduct practice in a way that complies with privacy principles.

CTRLC5.3 Continue to develop information management and evidence gathering skills.

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## *Undifferentiated conditions*

### **Contents**

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Definition	425
Curriculum in practice	425
Rationale and general practice context	426
Training outcomes of the five domains of general practice	428
Learning objectives across the GP professional life	430
<i>Medical student</i>	430
<i>Prevocational doctor</i>	432
<i>Vocational registrar</i>	434
<i>Continuing professional development</i>	436
References	437

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## Definition

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Undifferentiated conditions refer to ambiguous, uncertain, unexplained and undiagnosed symptoms, problems, conditions and illnesses presenting to the clinician.

The causes and management of undifferentiated conditions may become clearer through history, examination or investigations, or may become clearer over time as a disease process progresses. For example, a connective tissue disease such as systemic lupus erythematosus may first present as tiredness, but further investigation or the passage of time may result in the diagnosis becoming clearer. Similarly, the cause of an initial presentation of undiagnosed chest pain would become apparent if a dermatomal rash developed after 1 day, ie. herpes zoster.

Some undifferentiated conditions remain undiagnosed despite thorough assessment and investigation.

Some undifferentiated conditions may have a psychological origin, which presents potential challenges to patient safety because of the potential for missed, delayed or wrong diagnosis.

## Curriculum in practice

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The following presentation illustrates how the undifferentiated conditions curriculum applies to general practice:

- Mary, 55 years of age, presents feeling tired and run down but vaguely suggests that she may be lonely now that her children have left home. She finds herself heading to bed around 9 pm and sleeping through until 8 am but without feeling refreshed. With no family to cook for, she has lost her appetite, has begun to skip meals and thinks she may have lost weight. She thinks that is why she now feels the cold more. Her periods have become progressively lighter and she has noticed she doesn't need to shave her armpits as often and puts it down to 'change of life'. She thinks she will take up exercise and has begun walking every morning and although her skin has become quite tanned she remains feeling unfit and lacking in energy. At work it is hard to concentrate and she catches herself just staring vacantly. She is wondering if she might be depressed. Her blood pressure is BP 95/60 mmHg and physical examination is unremarkable.

## Rationale and general practice context

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Undifferentiated conditions are very likely to present in general practice. For example, the presentation of nonspecific weakness or tiredness is common in general practice and is the fifth commonest reason for initiating further pathology investigations in Australian general practice.<sup>1</sup>

General practitioners are primarily diagnosticians<sup>2</sup> and are highly experienced at managing undifferentiated conditions.

These conditions challenge diagnostic skills and clinical decision making processes, which aim to discover serious illness at an appropriately early stage while minimising over-investigation of patients.<sup>3</sup> The expertise in dealing with undifferentiated conditions places general practitioners in an ideal situation to educate and train other clinicians in this skill area, especially patient safety and situations of missed diagnoses.

Important differences exist between primary care and secondary/tertiary care medicine, with distinct differences between the patients, pathologies and presentations encountered by the GP compared to a specialist colleague.

Conditions seen in general practice are often evolving, and text book descriptions and classifications often do not apply.

Early presentations of many illnesses defy categorisation because they may be transient and self limiting, or are treated early, before reaching the stage of traditional diagnosis.

General practitioners may also have a different focus from specialists, with a management plan often having to be formulated without a precise diagnosis. A diagnosis may be framed in terms of dichotomous decisions: treatment versus nontreatment, referral versus nonreferral, and serious versus nonserious. For example, back pain may be successfully treated empirically in the absence of 'red flags', without an expectation of ever investigating further or confirming a diagnosis.<sup>2</sup>

The range of common undifferentiated conditions in general practice is large and includes such presentations as fatigue, insomnia, stress, dizziness, headache, anorexia, nausea, sexual difficulty, weight loss, apathy and abdominal discomfort.<sup>4</sup>

Understanding the role of the passage of time and knowledge of the natural history of these conditions are key in managing undifferentiated conditions.<sup>3</sup>

Undifferentiated conditions are commonly associated with clinical uncertainty and ambiguity, which presents management challenges for the clinician, including how to communicate these uncertainties to patients.<sup>2,5</sup>

The role of uncertainty in clinical outcomes is not clear. Uncertainty in clinical decision making has been linked to potential and actual adverse outcomes in patient care in the prevocational setting.<sup>6</sup> While one study of uncertainty in primary care physicians did not demonstrate differences in patient outcomes, physicians changed their approaches to information seeking.<sup>7</sup>

Clinical strategies for managing undifferentiated conditions need to adopt a 'fail-safe' strategy,<sup>8</sup> including regular review of the presentation, and recognising that some symptoms and presentations may never be attributed to specific conditions.

The potential for diagnostic uncertainty is compounded by somatisation, when psychological conditions present as physical symptoms. Clinicians need to remain alert to this potential and develop clear strategies for delineating physical and psychological components of the presenting conditions. Effective and appropriate management of somatisation may also require a multidisciplinary approach and professional support to ensure that diagnoses are not being missed.<sup>9,10</sup>

Being clear about decisions and referring to evidence during the history taking, examination

and investigations help maximise diagnostic effectiveness and patient safety and minimise over-investigation. This includes familiarity with serious conditions that must not be missed, conditions commonly missed and conditions that may present with unusual or elusive symptoms. Evidence based approaches to assessment and management<sup>10</sup> can help to clarify and strengthen decision making.

Develop familiarity with the disease patterns specific to the geographical areas of practice may help discern local variations in disease presentations and diagnoses compared with other regions. For example, higher than average presentations of hay fever in spring may be due to local pollen conditions.

Communication skills are critical to characterising undifferentiated conditions and to communicating management outcomes to patients.

Patients with limited capacity to give complete histories, for example, children, patients with dementia or some patients with disabilities, may need family, friends and carers to be consulted for further clarification. Clinicians need to observe confidentiality and the legal status of carers or guardians, and the potential for carers or guardians to abuse or misuse of the position by deliberately providing incorrect and misleading information concerning the patient.

Uncertainty can be a source of considerable anxiety for patients, and learning to manage this is a key general practice skill. Communication skills are the key to successful outcomes in managing undifferentiated conditions of a psychogenic origin.

## Related curriculum areas

Undifferentiated conditions affect many other curriculum statement areas, but in particular:

- *Critical thinking and research*
- *Quality and safety.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- UNDT1.1 Communicate clearly to help characterise symptoms as part of a diagnostic and management strategy for undifferentiated conditions in the general practice setting.
- UNDT1.2 When appropriate, take a history from family, carers and others, for example when patients are unable to give clear histories.
- UNDT1.3 Counsel patients safely and appropriately when managing uncertainty in diagnosis and management.

## 2. Applied professional knowledge and skills

- UNDT2.1 Use skilful history taking, examination processes and appropriate investigations when managing undifferentiated conditions in the primary care setting.
- UNDT2.2 Be familiar with early presentations of evolving conditions, their natural history and the impact of early treatment to help characterise undifferentiated conditions in the general practice setting.
- UNDT2.3 Manage any uncertainties that may arise in undifferentiated conditions that remain unexplained and undiagnosed despite thorough assessment and investigation.
- UNDT2.4 Use safe diagnostic strategies to minimise the risk of missed, delayed or wrong diagnoses.
- UNDT2.5 Understand how appropriate diagnostic tests reduce diagnostic uncertainty and help minimise inappropriate investigations.
- UNDT2.6 Diagnose and manage psychological factors in undifferentiated conditions.
- UNDT2.7 Implement periodic review of the undifferentiated problem to be alert to potential changes and development of symptoms and signs.

## 3. Population health and the context of general practice

- UNDT3.1 Understand that undifferentiated conditions are common in the general practice setting.
- UNDT3.2 Be familiar with common patterns of presentations of undifferentiated illnesses including transient and self limiting diseases and new complaints in patients with chronic disease.
- UNDT3.3 Be familiar with the patterns of serious ('red flag') conditions that should not be missed, difficult to diagnose conditions and common conditions that present as undifferentiated conditions.
- UNDT3.4 Understand that some undifferentiated conditions may have a psychological origin, and the potential challenges this may present to patient safety because of the potential for diagnostic errors.

## 4. Professional and ethical role

- UNDT4.1 Be aware of clinical decision making processes and the potential pitfalls in the diagnosis of undifferentiated conditions.
- UNDT4.2 Understand that primary care patients present with differing patterns of undifferentiated conditions compared to those presenting in the secondary/tertiary setting.
- UNDT4.3 Consider the role of experienced general practitioners in training registrars and others in the management of undifferentiated conditions. This includes teaching patient safety approaches to prevent missed, delayed or wrong diagnoses.

## 5. Organisational and legal dimensions

- UNDT5.1 When appropriate, work with multidisciplinary teams to successfully characterise and manage undifferentiated conditions.
- UNDT5.2 Consider the legal implications of potential diagnostic errors and seek appropriate and timely advice.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- UNDLM1.1 Discuss the ability to clearly characterise symptoms of undifferentiated conditions.
- UNDLM1.2 Discuss the ability to counsel patients when managing uncertainty of diagnosis and management.

### 2. Applied professional knowledge and skills

- UNDLM2.1 Describe the role of history, examination and appropriate investigations in managing undifferentiated conditions.
- UNDLM2.2 Discuss the decision making processes involved in making a diagnosis.
- UNDLM2.3 Discuss fail-safe diagnostic strategies.
- UNDLM2.4 Describe the role of appropriate diagnostic tests in reducing diagnostic uncertainty.
- UNDLM2.5 Describe the role of diagnosis in patient management when dealing with undifferentiated conditions.
- UNDLM2.6 Describe the factors that affect the presentation of undifferentiated conditions such as patient and environmental factors, and the natural history of a disease including transient and self limiting conditions.
- UNDLM2.7 Describe how early treatment can influence the natural history and presentations of disease.
- UNDLM2.8 Describe how psychological factors impact on undifferentiated conditions and their potential challenges to patient safety including diagnostic errors.
- UNDLM2.9 Outline management options when undifferentiated conditions remain undiagnosed despite thorough assessment and investigation.
- UNDLM2.10 Describe processes for counselling a patient when there is uncertainty regarding diagnosis and management.

### 3. Population health and the context of general practice

- UNDLM3.1 Outline the pattern of common presentations of undifferentiated conditions in the hospital and general practice setting.
- UNDLM3.2 Describe important presentations in undifferentiated conditions that should not be missed.
- UNDLM3.3 Describe the differences in disease presentations and management between primary care and secondary/tertiary care medicine.
- UNDLM3.4 Describe common patterns of psychological conditions that relate to the presentation of undifferentiated conditions.

## 4. Professional and ethical role

- UNDLM4.1 Describe appropriate professional behaviours when managing undifferentiated conditions.
- UNDLM4.2 Describe professional differences in diagnostic and management decision making between GPs and specialists.
- UNDLM4.3 Describe the impact of uncertainty for the patient and doctor in clinical decision making, and the potential for missed, delayed or wrong diagnosis.

## 5. Organisational and legal dimensions

- UNDLM5.1 Describe the multidisciplinary approaches managing undifferentiated conditions.
- UNDLM5.2 Describe the legal pitfalls and implications of managing undifferentiated conditions.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge — medical student

### 1. Communication skills and the patient-doctor relationship

- UNDLP1.1 Demonstrate the ability to clearly characterise symptoms of undifferentiated conditions.
- UNDLP1.2 Demonstrate the ability to counsel patients when managing uncertainty of diagnosis and management.

### 2. Applied professional knowledge and skills

- UNDLP2.1 Demonstrate the ability to take a history, examine and appropriately investigate in managing undifferentiated conditions.
- UNDLP2.2 Demonstrate fail-safe diagnostic strategies.
- UNDLP2.3 Request appropriate diagnostic tests to reduce diagnostic uncertainty.
- UNDLP2.4 Identify specific factors that affect the presentation of undifferentiated conditions.
- UNDLP2.5 Identify psychological factors in undifferentiated conditions.
- UNDLP2.6 Identify possible diagnoses that need to be excluded in undifferentiated conditions.
- UNDLP2.7 Discuss management options when undifferentiated conditions remain undiagnosed despite thorough assessment and investigation.
- UNDLP2.8 Demonstrate the ability to counsel a patient when there is uncertainty regarding diagnosis and management.

### 3. Population health and the context of general practice

- UNDLP3.1 Describe the pattern of common presentations of undifferentiated conditions in their current workplace(s).
- UNDLP3.2 Describe the patterns of commonly missed conditions in undifferentiated conditions in their current workplace(s).
- UNDLP3.3 Describe the patterns of important conditions that should not be missed in undifferentiated conditions in their current workplace(s).
- UNDLP3.4 Describe common patterns of psychological conditions that relate to the presentation of undifferentiated conditions in their current workplace(s).

## 4. Professional and ethical role

- UNDLP4.1 Demonstrate appropriate professional behaviours when managing undifferentiated conditions.
- UNDLP4.2 Describe the impact of uncertainty in clinical decision making and the potential for missed, delayed or incorrect diagnoses in specific cases of undifferentiated conditions currently being managed.

## 5. Organisational and legal dimensions

- UNDLP5.1 Describe the multidisciplinary approaches for the management of undifferentiated conditions in their current workplace(s).
- UNDLP5.2 Describe the legal pitfalls and implications of managing undifferentiated conditions in their current workplace(s).

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge — prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- UNDLV1.1 Demonstrate the ability to clearly characterise symptoms of undifferentiated conditions in the primary care setting.
- UNDLV1.2 Demonstrate the ability to counsel patients when managing uncertainty of diagnosis and management in the primary care setting.

### 2. Applied professional knowledge and skills

- UNDLV2.1 Demonstrate the ability to take a history, examine and appropriately investigate in managing undifferentiated conditions in the primary care setting.
- UNDLV2.2 Demonstrate fail-safe diagnostic strategies in the primary care setting.
- UNDLV2.3 Request appropriate diagnostic tests to reduce diagnostic uncertainty in the primary care setting.
- UNDLV2.4 Identify specific factors that affect the presentation of undifferentiated conditions in the primary care setting.
- UNDLV2.5 Identify psychological factors impacting upon undifferentiated conditions in the primary care setting.
- UNDLV2.6 Identify possible diagnoses that need to be excluded in undifferentiated conditions in the primary care setting.
- UNDLV2.7 Discuss management options when undifferentiated conditions remain undiagnosed despite thorough assessment and investigation in the primary care setting.
- UNDLV2.8 Demonstrate the ability to counsel a patient when there is uncertainty regarding diagnosis and management in the primary care setting.

### 3. Population health and the context of general practice

- UNDLV3.1 Describe the pattern of common presentations of undifferentiated conditions specific to the current primary care setting.
- UNDLV3.2 Describe the patterns of commonly missed conditions in undifferentiated conditions specific to the current primary care setting.
- UNDLV3.3 Describe the patterns of important conditions that should not be missed in undifferentiated conditions specific to the current primary care setting.
- UNDLV3.4 Describe common patterns of psychological conditions that relate to the presentation of undifferentiated conditions in the primary care setting.

## 4. Professional and ethical role

- UNDLV4.1 Demonstrate appropriate professional behaviours when managing undifferentiated conditions in the primary care setting.
- UNDLV4.2 Describe the impact of uncertainty in clinical decision making and the potential for missed, delayed or wrong diagnosis in specific cases of undifferentiated conditions being managed in the primary care setting.
- UNDLV4.3 Identify professional supports and mentors in the primary care setting for acquiring skills in the management of undifferentiated conditions (eg. colleagues, supervisors).

## 5. Organisational and legal dimensions

- UNDLV5.1 Describe the multidisciplinary approaches for the management of undifferentiated conditions in the primary care setting.
- UNDLV5.2 Describe the legal pitfalls and implications of managing undifferentiated conditions in the primary care setting.

# Learning objectives across the GP professional life

---

## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- UNDLC1.1 Demonstrate maintenance of competency in characterising symptoms of undifferentiated conditions in the primary care setting.
- UNDLC1.2 Demonstrate maintenance of competency in counselling patients when managing uncertainty of diagnosis and management in the primary care setting.

### 2. Applied professional knowledge and skills

- UNDLC2.1 Demonstrate maintenance of skill competencies in the assessment and management of undifferentiated conditions.
- UNDLC2.2 Request appropriate diagnostic tests to reduce diagnostic uncertainty in the primary care setting.

### 3. Population health and the context of general practice

- UNDLC3.1 Describe any trends in patterns of common presentations of undifferentiated conditions specific to their current primary care setting.
- UNDLC3.2 Describe any trends in commonly missed conditions in undifferentiated conditions specific to their current primary care setting.
- UNDLC3.3 Describe any trends in patterns of important conditions that should not be missed in undifferentiated conditions specific to their current primary care setting.

### 4. Professional and ethical role

- UNDLC4.1 Demonstrate appropriate professional behaviours when managing undifferentiated conditions in the primary care setting.
- UNDLC4.2 Outline professional processes for dealing with uncertainty in clinical decision making and the potential for missed, delayed or wrong diagnosis in specific cases of undifferentiated conditions currently being managed in the primary care setting.
- UNDLC4.3 Identify professional supports and mentors within the primary care setting for acquiring skills in the management of undifferentiated conditions (eg. colleagues, supervisors).
- UNDLC4.4 Consider a role in training registrars and others in the management of undifferentiated conditions in the general practice setting, for example, colleagues, supervisors and others. This includes teaching patient safety approaches to prevent missed, delayed or wrong diagnoses.
- UNDLC4.5 Consider further training in psychological management of undifferentiated conditions (eg. somatisation disorders).

### 5. Organisational and legal dimensions

- UNDLC5.1 Describe current practice processes for the multidisciplinary management of undifferentiated conditions.
- UNDLC5.2 Describe the legal pitfalls and risk management processes in place in the current workplace with respect to undifferentiated conditions.

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## *E-health*

### Contents

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Definition	441
Curriculum in practice	442
Rationale and general practice context	443
Training outcomes of the five domains of general practice	444
Learning objectives across the GP professional life	446
<i>Medical student</i>	446
<i>Prevocational doctor</i>	447
<i>Vocational registrar</i>	448
<i>Continuing professional development</i>	449
References	450

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## Definition

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E-health is a rapidly evolving component of healthcare and is a basic requirement for providing general practice care in the 21st century.<sup>1</sup>

E-health has been defined as ‘the transfer of health resources and healthcare by electronic means’.<sup>2</sup>

E-health is ‘the electronic collection, management, use, storage and sharing of healthcare information. This information can include individual items such as referrals, test results, discharge summaries, vaccination history, medication history and diagnoses’.<sup>3</sup>

E-health encompasses products, systems and services including tools for supporting healthcare. These tools are used by:

- health professionals
- health authorities
- patients
- the wider general community.

‘E-health systems that securely and efficiently exchange data can significantly improve how clinical and administrative information is communicated between healthcare providers. As a result, e-health systems have the potential to unlock substantially greater quality, safety and efficiency benefits. E-health has the capacity to benefit all Australians – individual consumers, healthcare providers and organisations’.<sup>3</sup>

The scope of e-health includes desktop to bedside and population health activities. These present complex information management challenges in supporting individualised patient care and present challenges for GPs in both clinical practice and practice administration.

‘Telehealth’ relates to the direct (eg. video conferencing) or indirect (eg. website delivery) delivery of health information or healthcare to a recipient. Telehealth essentially means ‘healing at a distance’ and involves both the electronic transmission and storage of health information/images in the delivery of both clinical and nonclinical health services utilising a range of telecommunications technologies.<sup>4,5</sup>

This curriculum statement was formerly known as ‘Health informatics’, which refers to the interdisciplinary field that deals with the collection, storage, retrieval, communication and optimal use of health related data, information and knowledge using information science for the purposes of problem solving, decision making and assuring high quality healthcare in biomedical sciences.<sup>6</sup>

## Curriculum in practice

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The following case illustrates how the e-health curriculum applies to general practice:

- Barry, 42 years of age, injured his knee while yarding cattle. Determined to complete the job while he had the help of his neighbour, he used fencing wire and a post to make a splint to support his leg. His knee is grossly swollen by the time he presents for review, hours after the injury. Your small hospital has a digital X-ray machine and you access real-time reporting in consultation with a specialist at the base hospital. Together you make a diagnosis of complicated fracture of the tibial plateau. Barry is transferred to the base hospital for surgery. The surgeon accesses the electronic films and books the theatre. Before discharge, the orthopaedic team arrange a video consultation with you – the treating GP – and the local physiotherapist, to outline what will be needed to aid Barry's recovery and what outcome milestones are anticipated. Each fortnight the two teams meet with Barry and demonstrate, on camera, his slow progress in regaining mobility. Although Barry is frustrated at not being fit enough to yard cattle, he has already returned to driving a tractor on the farm. Barry's son tells you that Barry has taken over a large part of the family finances, which has enabled Barry's wife to take on a greater role on the farm. This has helped the family to meet production targets, which would have not been possible if the family had to travel to the city for Barry's many medical appointments.

## Rationale and general practice context

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The rise in computerisation of Australian general practice for patient and data records has changed the way in which practices operate, as well as the dynamics of the patient-doctor relationship.

In 2009–2010, almost two-thirds (64%) of GPs reported using electronic records exclusively, 85% producing prescriptions electronically and 72% receiving pathology results on line.<sup>7</sup>

E-health is seen to be increasingly important in ensuring system efficiencies and improving quality of patient care,<sup>1</sup> and the rise in computer use in general practice has been described as responsible for creating the largest electronic database of clinical information in the country.<sup>3</sup>

The introduction of new technologies into general practice presents challenges for GPs. Future developments in the areas of a national health record system, e-billing and telehealth will need to be monitored by GPs and practice teams.

The use of information management can assist GPs to keep up-to-date with clinical advances through guidelines, summary services (eg. clinical evidence) and decision support.

General practitioners must be mindful of the potential risks of information management, including security and privacy issues, and need to be familiar with computer security guidelines.<sup>7–10</sup>

Effective use of medical records data can assist GPs to better understand their practice's patient base, facilitating the provision of services and deriving business benefits.

Patients are referring to the internet for information and younger users are using web based technologies for routine day-to-day communication. The increasing use of social media requires general practice to be aware of the changing implications and standards of using such technologies.<sup>15</sup>

### Related curriculum areas

E-health impacts on many areas of general practice, but in particular, refer also to the curriculum statements:

- *Chronic conditions*
- *Population health and public health*
- *Practice management.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- EHET1.1 Acknowledge, in conjunction with practice staff, that data collection and retrieval involves a relationship between the patient, practice team and computer.
- EHET1.2 Be conscious of the impact of technology on patient-doctor communication (eg. the perception that the computer is 'taking over' the consultation).
- EHET1.3 Acknowledge the three-way relationship between the patient, doctor and computer while ensuring that the patient-doctor relationship remains paramount.
- EHET1.4 Have the skills to communicate via distance technologies (eg. telehealth). Acknowledge barriers to quality and safety.

## 2. Applied professional knowledge and skills

- EHET2.1 Be aware of appropriate and reliable websites for patient information.
- EHET2.2 Have basic knowledge of booking and billing systems.
- EHET2.3 Understand the role of the electronic health record in general practice.
- EHET2.4 Use electronic prescribing systems effectively and safely.
- EHET2.5 Be familiar with search strategies for evidence based resources (eg. PubMed and Cochrane).
- EHET2.6 Use appropriate electronic resources (eg. websites, smartphone applications, e-books, information portals) for current professional information (eg. e-medicine, Harrison's Online, Dermnet, *BMJ's* Clinical Evidence).
- EHET2.7 Understand or be aware of your limitations (so as to seek appropriate assistance) regarding e-health systems and applications, for example, security and data recovery, telehealth including teleconsults, email consultations, electronic billing via Medicare Online, the use of templates for medical summaries, medication lists, care plans and health assessments.

## 3. Population health and the context of general practice

- EHET3.1 Understand how e-health has a key role in improving general practice population health strategies.
- EHET3.2 Understand how general practices that have an information management strategy can produce clean data for use in their own practice.
- EHET3.3 Understand how electronic strategies (in the form of recalls, reminders and clinical audits) can assist general practices to engage in population health activities (eg. Pap tests) and other preventive health activities.

## 4. Professional and ethical role

- EHET4.1 Engage in appropriate skill development to keep up with evolving medical technology and understand that mastering a computer in healthcare is independent of medical experience and knowledge.
- EHET4.2 Acknowledge the role of e-health in complementing traditional general practice through better provision of information and knowledge.
- EHET4.3 Use change management to assist the uptake of electronic health records and other e-health applications in general practice.

## 5. Organisational and legal dimensions

- EHET5.1 Understand the importance of strategic and long term system security and privacy, including virus protection, server firewall set up, encryption of patient information through emails or system networks, data recovery and back up procedures, and where needed, delegate these tasks to information technology professionals.
- EHET5.2 Understand that the electronic health record is a patient record and, like the paper based record, is a legal document.
- EHET5.3 Ensure data quality and up-to-date record keeping strategies are used.
- EHET5.4 Ensure that practice systems have dedicated resources or a third party is available to ensure a reliable service for all users.
- EHET5.5 Monitor, where appropriate, the role of e-health developments and emerging technologies in general practice.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- EHELM1.1 Describe how the use of a computer in a consultation can be a barrier to the patient-doctor relationship.
- EHELM1.2 Outline strategies that can assist in ensuring a patient centred consultation style while using a computer in a consultation.

### 2. Applied professional knowledge and skills

- EHELM2.1 Define basic computer literacy skills.
- EHELM2.2 Demonstrate basic computer literacy skills.
- EHELM2.3 Describe the role of electronic health records and prescribing systems in healthcare.
- EHELM2.4 Outline the role of the internet in patient care.

### 3. Population health and the context of general practice

- EHELM3.1 Outline how e-health can be used in preventive care.
- EHELM3.2 Outline how systems can be used for reminders and recalls.

### 4. Professional and ethical role

- EHELM4.1 Identify how e-health issues can impact on the GP, staff and patient.
- EHELM4.2 Identify change management issues that are associated with e-health.
- EHELM4.3 Describe the definitions of 'clean' data and data coding.
- EHELM4.4 Outline privacy issues for the patient and the practitioner in e-health issues including the role of social media.

### 5. Organisational and legal dimensions

- EHELM5.1 Describe issues that can affect e-health (eg. security and data protection).
- EHELM5.2 Outline legal implications in the usage of the electronic health record.
- EHELM5.3 Outline the basic infrastructure issues in relation to the day-to-day running of general practice (eg. program updates).

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- EHELP1.1 Demonstrate high level communication skills in the consultation (eg. the provision of information and the use of computer based decision aids in patient information).

### 2. Applied professional knowledge and skills

- EHELP2.1 Demonstrate expertise in using the internet to gain evidence based information that supports current practice.
- EHELP2.2 Outline e-health systems that support day-to-day general practice (eg. billing and booking systems, accounts keeping, Medicare Online).
- EHELP2.3 Demonstrate mastery of the electronic health record in daily practice (eg. prescriptions, reports, results checking, updating past history, recall systems, patient databases).

### 3. Population health and the context of general practice

- EHELP3.1 Demonstrate how e-health can improve the care of patients using recall and data-specific patient searches.

### 4. Professional and ethical role

- EHELP4.1 Demonstrate the correct use of coding in the electronic health record.
- EHELP4.2 Describe coding and the impact of data quality on patient care and practice administration.

### 5. Organisational and legal dimensions

- EHELP5.1 Identify when e-health is complementary to practice management.
- EHELP5.2 Identify legal implications for evolving technologies (eg. email consultations).
- EHELP5.3 Discuss critically privacy issues surrounding e-health and general practice.
- EHELP5.4 Discuss the role of encryption technologies for patient and population data transfer (eg. email).
- EHELP5.5 Describe the legal status of the electronic health record.
- EHELP5.6 Describe e-health infrastructure and systems in the general practice setting.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- EHELV1.1 Demonstrate high level communication skills in the consultation (eg. the provision of information and the use of computer based decision aids in patient information).
- EHELV1.2 Demonstrate, where appropriate to the patient's needs, how to consult via telehealth.

### 2. Applied professional knowledge and skills

- EHELV2.1 Demonstrate expertise in searching the internet for evidence based information that supports day-to-day practice.
- EHELV2.2 Outline high level e-health systems that support day-to-day general practice (eg. billing and booking systems, accounts keeping, Medicare Online).
- EHELV2.3 Demonstrate mastery of the electronic health record in daily practice (eg. prescriptions, reports, results checking, updating past history, recall systems, patient databases).

### 3. Population health and the context of general practice

- EHELV3.1 Demonstrate e-health principles to improve patient care using recall databases and data specific patient searches.

### 4. Professional and ethical role

- EHELV4.1 Demonstrate correct usage of coding in the electronic health record.
- EHELV4.2 Be familiar with professional responsibilities and requirements as detailed in e-health general practice guidelines (eg. RACGP *Standards for general practices*, *Computer information and security standards*, telehealth guidelines, social media guidelines).

### 5. Organisational and legal dimensions

- EHELV5.1 Identify characteristics which make e-health complementary to practice management.
- EHELV5.2 Identify legal implications for evolving technologies (eg. email consultations).
- EHELV5.3 Discuss critically privacy issues surrounding e-health and general practice.
- EHELV5.4 Discuss the role of encryption technologies for patient and population data transfer.
- EHELV5.5 Describe the legal status of the electronic health record.
- EHELV5.6 Describe e-health infrastructure and systems in the general practice setting.
- EHELV5.7 Understand the legal responsibility of recall and reminder systems.
- EHELV5.8 Ensure familiarity with general practice standards for e-health (eg. computer security guidelines, privacy for telehealth guidelines).

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- EHELC1.1 Demonstrate continuing evaluation of consultation skills for patient centred practice.
- EHELC1.2 Demonstrate effective communication skills with colleagues and staff when using e-health systems.

### 2. Applied professional knowledge and skills

- EHELC2.1 Demonstrate mastery of skills in using the internet for patient and self education purposes.
- EHELC2.2 Demonstrate high level skills in using the electronic health record for care planning, health assessments and monitoring of up-to-date data (eg. medications and past history).
- EHELC2.3 Describe billing and booking systems that assist patient focused service delivery.

### 3. Population health and the context of general practice

- EHELC3.1 Identify ongoing issues with data quality and how this might be improved.
- EHELC3.2 Identify patient key performance indicators to inform practice quality.

### 4. Professional and ethical role

- EHELC4.1 Demonstrate effective change management principles, especially toward colleagues and general practice staff.
- EHELC4.2 Outline continuing professional development activities that could be provided for topics where traditional training and education are not available (eg. RACGP online learning).

### 5. Organisational and legal dimensions

- EHELC5.1 Describe the processes in place at your practice that initiate data recovery in the event of a system shutdown.
- EHELC5.2 Describe practice processes in relation to hardware and software update requirements.
- EHELC5.3 Identify issues to consider when a third party is responsible for information technology infrastructure.
- EHELC5.4 Demonstrate consideration of legal and privacy issues in e-health, including encryption of patient data and patient ownership of electronic data.
- EHELC5.5 Describe strategies that could assist GPs in the transition to the paperless patient record.
- EHELC5.6 Describe coding and its impact on clean patient information for self and third party information requirements.

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## *Multidisciplinary care*

### Contents

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Definition	453
Curriculum in practice	453
Rationale and general practice context	454
Training outcomes of the five domains of general practice	456
Learning objectives across the GP professional life	458
<i>Medical student</i>	458
<i>Prevocational doctor</i>	460
<i>Vocational registrar</i>	462
<i>Continuing professional development</i>	464
References	466

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## Definition

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Multidisciplinary care occurs when professionals from a range of disciplines with different but complementary skills, knowledge and experience work together to deliver comprehensive healthcare aimed at providing the best possible outcome for the physical and psychosocial needs of a patient and their carers. As patient needs may change with time, the composition of the team may also change to meet these needs.<sup>1</sup>

A strong culture of multidisciplinary care is seen as critical to improving the primary healthcare of Australia.<sup>2</sup>

## Curriculum in practice

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The following case illustrates how the multidisciplinary care curriculum applies to general practice:

- Mick, 37 years of age, is an Aboriginal man who was diagnosed with diabetes at age 16 years. His urinalysis reveals 3+ proteinuria, his vision is poor and he has peripheral neuropathy along with an ulcerated rash of his lower legs. Morbidly obese, his sugar levels have seldom been recorded at less than 30 and yet he has refused all treatment on the basis that, 'Diabetes means I'm going to die anyway so what's the point?' He presents following the death of his sister, who had been on dialysis for several years for diabetic nephropathy. As he is now the carer for his nephew he is motivated to take more care of his health and wants your assistance.

## Rationale and general practice context

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While multidisciplinary care provides a more diverse range of skills and experience than a single health professional does, co-ordination and continuity of care, and clinical team leadership is a primary function of the general practitioner,<sup>1,3</sup> even though primary care participation in multidisciplinary teams may be initiated outside the general practice setting.<sup>1</sup>

Successful multidisciplinary care requires GPs to be able to build continuous, close and respectful therapeutic relationships with patients to deliver accessible, integrated patient care. This involves leading, supporting and co-ordinating flexibly configured clinical teams and engaging with diverse specialists and other sector services according to individual patient or family needs. In addition, the GP is increasingly the custodian of, and conduit for, key patient clinical information.<sup>3</sup>

While multidisciplinary teams enable a more comprehensive approach to meeting the comprehensive needs of individual patients, GPs still need to be able to provide day-to-day care of episodic and chronic conditions.<sup>1</sup>

### The role of the general practitioner in multidisciplinary care

The rise of care planning in many areas of chronic disease has resulted in an increasing role of GPs in multidisciplinary care.<sup>4</sup> Team based care in primary care clinical areas such as diabetes, aged care, mental health and disability have led to the emergence of systematic approaches of team based care, both within and outside of practices<sup>1</sup> as reflected in the role of co-ordinated and comprehensive care in the recently revised RACGP definition of general practice:

‘General practice provides person centred, continuing, comprehensive and co-ordinated wholeperson healthcare to individuals and families in their communities’.<sup>3</sup>

General practitioners need to operate within teams across diverse clinical settings such as between primary healthcare services and hospital based and or practice based clinicians to provide comprehensive team based care. This implies differences in governance structure and funding models. However, GPs have a gatekeeping role within the multidisciplinary care team.

Key GP skills for working within multidisciplinary settings include:

- identifying multidisciplinary team members and how they function especially when working with complex health needs and differing environments
- clear communication and interaction between team members
- mutual respect, trust and inclusiveness between team members
- the best use of the skill mix within the team
- good clinical governance.

General practitioners need to be able to work to overcome common barriers to multidisciplinary care such as:<sup>8</sup>

- time constraints
- lack of systems that promote teamwork including financing and infrastructure
- fragmentation due to a predominantly part time workforce
- lack of understanding about how teams function
- professional issues such as individual accountability

General practice needs to be well organised to implement effective team based management of chronic disease<sup>9</sup> requiring clinical leadership on the part of the GP.<sup>8</sup>

## Related curriculum areas

Refer also to the curriculum statements:

- *Aged care*
- *Chronic conditions*
- *Disability*
- *E-health*
- *Mental health*
- *Population health and public health*
- *Practice management*
- *Teaching, mentoring and leadership in general practice.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- MDCT1.1 Negotiate common ground with patients about their problems and expectations from team based care.
- MDCT1.2 Negotiate an effective management plan with patients including defining respective responsibilities and limits with the patient, family and carers.
- MDCT1.3 Communicate clearly and clarify the various roles and responsibilities of the multidisciplinary care team members with the patient, family and carers.
- MDCT1.4 Discuss the patient's understanding of the problem, management, advice and follow up within the multidisciplinary team setting.

## 2. Applied professional knowledge and skills

- MDCT2.1 Negotiate, prioritise and implement patient management within the multidisciplinary setting.
- MDCT2.2 Be able to co-ordinate care within multidisciplinary teams.
- MDCT2.3 Understand the role and functioning of multidisciplinary care especially within the context of chronic disease or complex health needs.
- MDCT2.4 Define the members of a multidisciplinary team for individual patients and their skills, roles and responsibilities and how they function.
- MDCT2.5 Identify and use hospital and community based expertise, resources and networks effectively.
- MDCT2.6 Recognise opportunities for health promotion and education and respond appropriately to increase the patient's capacity for self care within the multidisciplinary setting.
- MDCT2.7 Make appropriate and timely decisions about referral and follow up.

## 3. Population health and the context of general practice

- MDCT3.1 Understand the role of the GP in multidisciplinary care in the Australian health system (including care planning, services funding, policies and community resources).
- MDCT3.2 Recognise and respond to how a patient's cultural and linguistic diversity and their relationships with family and significant others may impact upon interactions with multidisciplinary healthcare providers outside of the general practice setting.
- MDCT3.3 Incorporate cultural and linguistic diversity into general practice multidisciplinary management.
- MDCT3.4 Know the availability of local, regional and national multidisciplinary care services.

## 4. Professional and ethical role

- MDCT4.1 Understand the GP's role within the multidisciplinary team.
- MDCT4.2 Practice and promote respect, trust and inclusiveness between multidisciplinary care team members.
- MDCT4.3 Understand the gatekeeper role of GPs in multidisciplinary team care.
- MDCT4.4 Act as a patient advocate appropriate within the multidisciplinary setting.
- MDCT4.5 Describe the accountability of GPs within multidisciplinary care.
- MDCT4.6 Apply clinical leadership skills appropriately within the multidisciplinary team.
- MDCT4.7 Show respect for a patient's culture and values, and an awareness of how these impact on the therapeutic relationship within general practice multidisciplinary care.
- MDCT4.8 Respect patient informed consent and privacy when working with other members of a multidisciplinary team.

## 5. Organisational and legal dimensions

- MDCT5.1 Communicate and interact clearly with all members of the general practice multidisciplinary team.
- MDCT5.2 Understand the role of practice systems in providing clear communication with all practice members.
- MDCT5.3 Understand the accountability of all of the members of a multidisciplinary team.
- MDCT5.4 Use time management skills during multidisciplinary team care.
- MDCT5.5 Understand the importance of open, supportive environments for open discussion with multidisciplinary team members to promote quality care.
- MDCT5.6 Understand the role of clinical governance in multidisciplinary care in the general practice setting and how this may interact with other organisations' governance.
- MDCT5.7 Understand the role of general practice medical records in co-ordinating clinical care within a multidisciplinary setting including the role of practice information management and data systems relating to: clinical standards, guidelines and protocols; medical records; information technology; communication and transfer of patient-related information; screening, recall and related systems; and access and confidentiality.
- MDCT5.8 Evaluate practice management skills relating to patient access guidelines; staff management; teamwork; office policies and procedures; financial and resource management.
- MDCT5.9 Incorporate medicolegal knowledge and responsibilities relating to multidisciplinary care with respect to: certification; confidentiality; legal report writing; prescribing; informed consent; duty of care; litigation.
- MDCT5.10 Use effective time management skills in multidisciplinary care.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- MDCLM1.1 Discuss the importance of negotiating common ground with patients about their problems and expectations from team based care in multidisciplinary care.
- MDCLM1.2 Outline the structure of effective multidisciplinary management plans with patients including defining respective responsibilities and limits with the patient, family and carers.
- MDCLM1.3 Outline the need for communicating clearly and clarifying the various roles and responsibilities of the multidisciplinary care team members with the patient, family and carers.
- MDCLM1.4 Outline issues affecting the patient's understanding of the problem, management, advice and follow up during multidisciplinary care.

### 2. Applied professional knowledge and skills

- MDCLM2.1 Describe the key features of multidisciplinary care.
- MDCLM2.2 Compare multidisciplinary care to care with a single healthcare provider.
- MDCLM2.3 Describe how to negotiate, prioritise and implement patient multidisciplinary care.
- MDCLM2.4 Describe the range of members of a multidisciplinary team and outline their skills, roles and responsibilities.
- MDCLM2.5 Outline how to make appropriate and timely decisions about referral and follow up.

### 3. Population health and the context of general practice

- MDCLM3.1 Describe multidisciplinary care within the Australian health system including the role of the GP.
- MDCLM3.2 Describe the impact of cultural and linguistic diversity on multidisciplinary care.

### 4. Professional and ethical role

- MDCLM4.1 Outline professional responsibilities within a multidisciplinary team including lines of accountability.
- MDCLM4.2 Describe the importance of respect, trust and inclusiveness for multidisciplinary care team members.
- MDCLM4.3 Discuss the need for respecting a patient's culture and values within the therapeutic relationship within multidisciplinary care.
- MDCLM4.4 Describe the role of patient informed consent and privacy when releasing patient information to other members of a multidisciplinary team.

## 5. Organisational and legal dimensions

- MDCLM5.1 Outline the importance of clear communication lines with all members of the multidisciplinary care team.
- MDCLM5.2 Describe the role of systems in providing clear communication with all members of a multidisciplinary team.
- MDCLM5.3 Describe the need for open discussion with multidisciplinary team members to promote quality care.
- MDCLM5.4 Outline the role of medical records in co-ordinating clinical care.
- MDCLM5.5 Outline the need for accurate and legible recordings of consultations and referrals, to enable continuity of care.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- MDCLP1.1 Demonstrate the ability to negotiate common ground with patients about their problems and expectations from team based care in multidisciplinary care.
- MDCLP1.2 Make effective management plans with patients including defining respective responsibilities and limits with the patient, family and carers.
- MDCLP1.3 Demonstrate how to communicate clearly and clarify the various roles and responsibilities of the multidisciplinary care team members with the patient, family and carers.
- MDCLP1.4 Discuss the patient's understanding of the problem, management, advice and follow up during multidisciplinary care.

### 2. Applied professional knowledge and skills

- MDCLP2.1 Demonstrate the ability to negotiate, prioritise and implement patient multidisciplinary care.
- MDCLP2.2 Describe the role and functioning of multidisciplinary care.
- MDCLP2.3 List the members of a multidisciplinary team for individual patients and outline the skills, roles and responsibilities of each member and their functions.
- MDCLP2.4 Demonstrate ability to make appropriate and timely decisions about referral and follow up.

### 3. Population health and the context of general practice

- MDCLP3.1 Outline the role of the GP in multidisciplinary care in the Australian health system.
- MDCLP3.2 Outline the special issues in multidisciplinary healthcare when working with patients from culturally and linguistically diverse backgrounds, including the impact on their relationships with family and significant others.

### 4. Professional and ethical role

- MDCLP4.1 Describe the prevocational doctor's roles and responsibilities within the multidisciplinary team.
- MDCLP4.2 Demonstrate respect, trust and inclusiveness for multidisciplinary care team members include those in general practice.
- MDCLP4.3 Demonstrate respect for a patient's culture and values, and an awareness of how these impact on the therapeutic relationship within multidisciplinary care.
- MDCLP4.4 Describe the role of patient informed consent and privacy when releasing patient information to other members of a multidisciplinary team.

## 5. Organisational and legal dimensions

- MDCLP5.1 Communicate and interact clearly with all members of the multidisciplinary team including with general practice.
- MDCLP5.2 Describe the role of organisational systems in providing clear communication with all members of a multidisciplinary team.
- MDCLP5.3 Outline the importance of open, supportive environments for open discussion with multidisciplinary team members to promote quality care.
- MDCLP5.4 Outline the role of medical records in co-ordinating clinical care within a multidisciplinary setting.
- MDCLP5.5 Make accurate and legible recordings of consultations and referrals, to enable continuity of care.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- MDCLV1.1 Demonstrate the ability to negotiate common ground with patients about their problems and expectations from team based care in the general practice setting.
- MDCLV1.2 Make effective general practice management plans with patients including defining respective responsibilities and limits with the patient, family and carers.
- MDCLV1.3 Demonstrate how to communicate clearly and clarify the various roles and responsibilities of the multidisciplinary care team members with the patient, family and carers in the general practice setting.
- MDCLV1.4 Discuss the patient's understanding of the problem, management, advice and follow up during multidisciplinary care in the general practice setting.

### 2. Applied professional knowledge and skills

- MDCLV2.1 Demonstrate the ability to negotiate, prioritise and implement patient multidisciplinary care within the general practice setting.
- MDCLV2.2 Demonstrate how to co-ordinate care within multidisciplinary teams.
- MDCLV2.3 Describe the role and functioning of multidisciplinary care especially within the context of chronic disease or complex health needs and how this may change over time.
- MDCLV2.4 List the members of a multidisciplinary team for individual patients and outline the skills, roles and responsibilities of each member and how they function in the general practice setting.
- MDCLV2.5 Identify and use hospital and community based expertise, resources and networks effectively.
- MDCLV2.6 Describe how to use opportunities for health promotion and education and their multidisciplinary management within the general practice setting.
- MDCLV2.7 Demonstrate the ability to make appropriate and timely decisions about referral and follow up.

### 3. Population health and the context of general practice

- MDCLV3.1 Describe the role of the GP in multidisciplinary care in the Australian health system including care planning, services funding, policies and community resources.
- MDCLV3.2 Outline the management of referrals and interactions with multidisciplinary healthcare providers outside of the general practice setting with patients from culturally and linguistically diverse backgrounds, including the impact on their relationships with family and significant others.
- MDCLV3.3 Outline the availability of local, regional and national multidisciplinary care services.

## 4. Professional and ethical role

- MDCLV4.1 Describe the roles and responsibilities of the GP within the multidisciplinary team including the role as patient advocate, a leader, and co-ordinator of care.
- MDCLV4.2 Demonstrate respect, trust and inclusiveness for multidisciplinary care team members.
- MDCLV4.3 Describe the gatekeeper role of GPs in multidisciplinary care team.
- MDCLV4.4 Demonstrate respect for a patient's culture and values, and an awareness of how these impact on the therapeutic relationship within general practice multidisciplinary care.
- MDCLV4.5 Describe the role of patient informed consent and privacy when working with other members of a multidisciplinary team.

## 5. Organisational and legal dimensions

- MDCLV5.1 Communicate and interact clearly with all members of the general practice multidisciplinary team.
- MDCLV5.2 Describe the role of practice systems in providing clear communication with all practice members.
- MDCLV5.3 Demonstrate effective time management skills during multidisciplinary team care.
- MDCLV5.4 Outline the importance of open, supportive environments for open discussion with multidisciplinary team members to promote quality care in the general practice setting.
- MDCLV5.5 Describe the role of clinical governance in multidisciplinary care in the general practice setting and how this may interact with other organisations' governance.
- MDCLV5.6 Outline the role of general practice medical records in co-ordinating clinical care within a multidisciplinary setting including the role of practice information management and data systems relating to: clinical standards, guidelines and protocols; medical records; information technology; communication and transfer of patient-related information; screening, recall and related systems; and access and confidentiality.
- MDCLV5.7 Describe the processes for evaluating practice management skills relating to patient access guidelines; staff management; teamwork; office policies and procedures; financial and resource management.
- MDCLV5.8 Outline the medicolegal knowledge and responsibilities relating to multidisciplinary care with respect to: certification; confidentiality; legal report writing; prescribing; informed consent; duty of care; litigation.
- MDCLV5.9 Make accurate and legible recordings of consultations and referrals, to enable continuity of care by GPs and other colleagues involved.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- MDCLC1.1 Demonstrate the ability to adapt communication skills to evolving multidisciplinary care structures that occur as a patient's needs evolve over time.
- MDCLC1.2 Demonstrate the ability to review and refine effective general practice management plans with patients including defining respective responsibilities and limits with the patient, family and carers.

### 2. Applied professional knowledge and skills

- MDCLC2.1 Demonstrate the ability to negotiate, prioritise and implement patient multidisciplinary care within the general practice setting as a patient's needs evolve over time.
- MDCLC2.2 Demonstrate how to co-ordinate care within evolving multidisciplinary teams.
- MDCLC2.3 Describe building links and relationships between the general practice and hospital and community based expertise, resources and networks.
- MDCLC2.4 Demonstrate the use of opportunities for health promotion and education and their multidisciplinary management within the general practice setting.

### 3. Population health and the context of general practice

- MDCLC3.1 Incorporate Australian health system multidisciplinary programs and policies into the general practice setting including care planning, services funding, and community resources.
- MDCLC3.2 Demonstrate the management of referrals and interactions with multidisciplinary healthcare providers outside of the general practice setting with patients from culturally and linguistically diverse backgrounds, including the impact on their relationships with family and significant others.

### 4. Professional and ethical role

- MDCLC4.1 Demonstrate meeting the GP's roles and responsibilities within the multidisciplinary team including the role as patient advocate, and leader and co-ordinator of care.
- MDCLC4.2 Demonstrate the incorporation of patient informed consent and privacy into multidisciplinary care.

## 5. Organisational and legal dimensions

- MDCLC5.1 Apply practice systems to the provision of clear communication with all practice members.
- MDCLC5.2 Demonstrate effective time management skills during multidisciplinary team care.
- MDCLC5.3 Describe how open discussion is promoted with multidisciplinary team members to promote quality care within the general practice setting.
- MDCLC5.4 Demonstrate clinical governance measures in place for multidisciplinary care in the general practice setting.
- MDCLC5.5 Describe the practice's medical record policies and procedures in place to co-ordinate clinical care within a multidisciplinary setting including the role of practice information management and data systems relating to: clinical standards, guidelines and protocols; medical records; information technology; communication and transfer of patient related information; screening, recall and related systems; and access and confidentiality.
- MDCLC5.6 Demonstrate processes for evaluating practice management skills relating to patient access guidelines; staff management; teamwork; office policies and procedures; financial and resource management.

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## *Integrative medicine*

### Contents

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Definition	469
Curriculum in practice	470
Rationale and general practice context	471
Training outcomes of the five domains of general practice	473
Learning objectives across the GP professional life	475
<i>Medical student</i>	475
<i>Prevocational doctor</i>	476
<i>Vocational registrar</i>	477
<i>Continuing professional development</i>	478
References	479

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## Definition

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Integrative medicine refers to the blending of conventional and evidence based complementary medicines and therapies with the aim of using the most appropriate of either or both modalities to care for the patient as a whole. Integrative medicine, like general practice, embraces and encourages a holistic approach to practice that incorporates patient involvement in self healthcare, prevention and lifestyle interventions. Integrative medicine encompasses more than complementary medicine, although this integration is an important and obvious aspect of integrative medicine.

Integrative medicine also describes a style of clinical practice and is best defined as ‘the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing’.<sup>1</sup>

For the purposes of the RACGP curriculum, complementary medicine will refer to evidence based therapies and medicines that are not conventionally used by doctors, but may complement medical management and be successfully integrated into it – whether the therapy is delivered by a doctor or a suitably trained complementary medicine practitioner.

The National Center for Complementary and Alternative Medicine classifies complementary and alternative therapies, regardless of any supporting evidence base, into five categories or domains.<sup>2</sup>

### Alternative medical systems

Alternative medical systems are built on complete systems of theory and practice. Examples of alternative medical systems that have developed in Western cultures include homeopathic medicine and naturopathic medicine. Examples of systems that have developed in non-Western cultures include traditional Chinese medicine, acupuncture and Ayurveda.

### Mind-body interventions

Mind-body medicine uses a range of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms. Some techniques, which were considered complementary and alternative therapies in the past, have become mainstream (eg. patient support groups and cognitive behavioural therapy). Other mind-body techniques are still considered complementary and alternative therapies. These include meditation, prayer, mental healing, and therapies that use creative outlets such as art, music or dance.

### Biologically based therapies

Biologically based therapies in complementary and alternative therapies use substances found in nature such as herbs, foods, and vitamins. Some examples include dietary supplements and herbal products. Some uses of dietary supplements have been incorporated into conventional medicine, for example, folic acid for prevention of neural tube defects and cholecalciferol when serum vitamin D levels are below normal for the prevention of osteoporosis.

### Manipulative and body based methods

Manipulative and body based methods in complementary and alternative therapies are based on manipulation and/or movement of one or more parts of the body. Some examples include chiropractic or osteopathic manipulation and massage.

## Energy therapies

Energy therapies involve the use of energy fields. They are of two types.

Biofield therapies involve the existence of energy fields that have not been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include qi gong, Reiki and therapeutic touch.

Bioelectromagnetic based therapies involve the unconventional use of electromagnetic fields such as pulsed fields, magnetic fields, or alternating current or direct current fields.

Due to the changing nature of evidence and clinical practice there is a grey area about whether some particular therapies are classified as complementary or conventional.

## Curriculum in practice

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Typical presentations that illustrate how the Integrative medicine curriculum applies to general practice include:

- Malcolm, 38 years of age, is a financial controller who presents with problems sleeping. He says he is often tired and, after extensive investigations, you come to the conclusion that there are no serious illnesses contributing to his tiredness. He is now requesting assistance with sleeping, but he says that he doesn't want to take any pills. What approaches can you take?
- Helen, 52 years of age, is an active woman who presents to her general practitioner. For the past 3 months she has been experiencing mild, but frequent hot flushes and night sweats with associated sleep disturbance. Her last period was 13 months ago. She has been previously well and is taking no medications. She is keen to explore 'natural' management of her menopausal symptoms. What do you advise?
- Brenda, 28 years of age, is a bank officer. She has been taking warfarin and has a past history of valvular disease. She presents for a routine INR check. She says she is thinking of taking some 'natural supplements', and asks if any of them would interfere with her warfarin.

## Rationale and general practice context

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A significant driver for integrative medicine has been the rising community interest in complementary medicine. General practitioners need to be familiar with a number of areas within integrative medicine. This may be because the doctor:

- would like to take an integrative medicine approach to their medical practice
- needs to be able to discuss integrative medicine or complementary medicine with their patients, including finding out current patterns of integrative medicine use, if any
- may need to know where to find quality information to answer clinical questions.

Nearly two-thirds of the community have used some form of complementary medicine and many do not disclose this to their doctor. Research has demonstrated as high as 57% of people taking complementary medicines do not tell their doctor and about 50% used conventional medicines on the same day.<sup>3</sup> These potentially unsafe situations need to be addressed.<sup>2,4</sup> Patients with chronic diseases are increasingly looking for healthcare outside conventional health systems.

Some doctors may not be confident in dealing with complementary medicine-related issues and may have limited awareness of the evidence base and potential safety issues associated with use. Consequently, they fail to ask patients about use of complementary medicines. Nevertheless, an increasing number of doctors are using complementary medicine or referring patients for complementary medicine.<sup>5</sup>

Australian general practitioners report<sup>6,7</sup> high levels of interest in learning about complementary medicine and the evidence base for these therapies. Over 30% of Australian GPs in a national survey identified themselves as practising integrative medicine and the majority of doctors (>80%) surveyed requested more education and research in complementary medicine.<sup>4</sup>

There is a higher acceptance of complementary medicines in other parts of the world than in Australia. For example, 64% of medical courses in the United States have content on complementary medicine.<sup>8,9</sup> Patients not satisfied with conventional medicine<sup>10</sup> often self prescribe complementary medicines without professional supervision emphasising the need for GPs who use integrative medical approaches.

General practitioners who want to pursue more detailed study in integrative medicine need to be familiar with the range, quality and standards, as well as education in this area.

### Integrative medicine in general practice

General practitioners are ideally placed to assist patients with integrative medicine due to their broad-based scientific and generalist training and their regular contact with the community.

Comprehensive integrative medicine training aims to:

- provide a greater range of therapeutic options to patients
- help patients make safe and balanced decisions regarding complementary medicine use
- avoid potentially harmful interactions between complementary and conventional therapies.

Integrative medicine does not reject or compete with conventional healthcare and overlaps significantly with what is currently widely accepted as quality general practice. Integrative medicine seeks to broaden conventional healthcare by emphasising principles that some doctors and patients believe are undervalued in conventional medical practice. Integrative medicine emphasises a number of issues including:

- a focus on wellness and illness prevention
- being holistic in nature by focusing on physical, psychological, spiritual, social and lifestyle issues
- incorporating evidence based, safe and ethical complementary therapies
- individualising the approach to any particular patient or clinical situation using the best of all available modalities in conjunction with informed patient choice
- integrating all of the above into conventional medical care
- acknowledging that advances in healthcare will be dependent on scientific advances, improvements in healthcare delivery systems, cultural change as well as practitioner and patient education.

A comprehensive approach to integrative medicine involves more than adding a little complementary knowledge to the 'kit bag' of the GP. Integrative medicine incorporates a philosophy of healthcare, as well as a way of practising. Prevention, holism and informed patient choice are obviously integral to the whole of general practice, and therefore the complementary aspects are often given the most attention when considering what integrative medicine is.

For this reason, integrative medicine training is not seen as a separate or stand alone aspect of general practice training. Some aspects of integrative medicine may be taught as stand alone modules, or in integrative medicine seminars and case discussions, but are best understood and applied when integrated appropriately into other aspects of general practice training. For example, when a doctor is learning about the management of depression or cardiovascular disease, training and case studies should integrate important principles of integrative medicine.

## Related curriculum areas

Refer also to the curriculum statement:

- *Quality use of medicines.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- INTT1.1 Communicate effectively with patients about integrative medicine, including taking a nonjudgmental history about the use of complementary medicines and self care issues, while responding to a patient's context in terms of history, culture, gender, race, spirituality and personal choices.
- INTT1.2 Assist patients to make decisions about their philosophy of healthcare and what treatment modality is best for them.
- INTT1.3 Be able to refuse unreasonable requests and set limits for patients.
- INTT1.4 Effectively communicate some integrative medicine skills, for example, relaxation techniques.

## 2. Applied professional knowledge and skills

- INTT2.1 Know the definitions, philosophy and main modalities of integrative medicine.
- INTT2.2 Have a basic, broad knowledge of the integrative medicine field, as well as the principles for appropriate use in conventional medical practice.
- INTT2.3 Be aware of the current evidence for widely used complementary medicines.
- INTT2.4 Know important interactions and side effects (common and/or severe) associated with complementary medicines.
- INTT2.5 Have the necessary skills to implement behaviour change and lifestyle strategies.
- INTT2.6 Know how to access quality sources of information on integrative medicine to suit both therapist and patient needs.
- INTT2.7 When appropriate, know about or how to use a number of complementary modalities, which are safe and well supported by evidence. Know how to deal with situations where knowledge is lacking and how to access quality information to help guide clinical decisions. This may not apply to all GPs.
- INTT2.8 When appropriate, manage common conditions using or offering complementary medicines. Also develop an integrative management plan for patients with chronic and complex illnesses, including combining complementary and conventional medicine. This may not apply to all GPs.

## 3. Population health and the context of general practice

- INTT3.1 Know the usage patterns of integrative and complementary medicine in the community.
- INTT3.2 Be aware of attitudes and cultural factors (such as the use of traditional Chinese medicine in the Chinese community) toward the use of complementary therapies, both in the community and the medical profession.

## 4. Professional and ethical role

- INTT4.1 Adopt appropriate clinical attitudes toward complementary therapies including respect, openness and tolerance for patients' choices and experiences. Also display these attitudes to nonmedical complementary practitioners while giving advice and direction when choices may be unsafe, as for any informed consent process.
- INTT4.2 Recognise presentations that require more intensive or specialised integrative medical management.
- INTT4.3 Be able to deal with interdisciplinary issues and communicate with medical and nonmedical complementary practitioners.
- INTT4.4 Apply general ethical principles to integrative medical clinical situations.
- INTT4.5 Be aware of professional legislative requirements and regulations regarding complementary medicines.

## 5. Organisational and legal dimensions

- INTT5.1 Maintain an awareness of medicolegal issues relating to integrative and complementary medicine issues.
- INTT5.2 Be up-to-date with current laws and regulations regarding the use of complementary medicines including medical indemnity implications.

## Learning objectives across the GP professional life

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### Medical student

#### 1. Communication skills and the patient-doctor relationship

- INTLM1.1 Demonstrate an ability to take a history about the use of complementary therapies in a nonjudgmental manner.

#### 2. Applied professional knowledge and skills

- INTLM2.1 Define integrative medicine and complementary medicine.  
INTLM2.2 Describe the philosophy of integrative medicine.  
INTLM2.3 Describe the main modalities of integrative medicine.  
INTLM2.4 Describe the current evidence and risks of widely used complementary medicines.

#### 3. Population health and the context of general practice

- INTLM3.1 Describe the general safety issues of complementary medicines.  
INTLM3.2 Describe the community usage and attitudes toward integrative medicine and complementary medicines.

#### 4. Professional and ethical role

- INTLM4.1 Describe the principles for the appropriate use of integrative medicine in conventional medical practice.

#### 5. Organisational and legal dimensions

- INTLM5.1 Describe important integrative medicolegal and ethical issues.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

INTLP1.1 Demonstrate an ability to assist patients to make decisions about what treatment modality is best for them.

### 2. Applied professional knowledge and skills

INTLP2.1 Demonstrate management of common conditions using or offering integrative medicine where appropriate.

INTLP2.2 Describe important interactions and side effects (common and/or severe) associated with complementary medicines.

### 3. Population health and the context of general practice

INTLP3.1 Outline the impact of integrative medicine on the community and medical profession.

### 4. Professional and ethical role

INTLP4.1 Demonstrate application of ethical principles to simple clinical situations involving complementary medicines.

INTLP4.2 Describe how to deal with interdisciplinary issues.

### 5. Organisational and legal dimensions

INTLP5.1 Demonstrate ability to effectively communicate with medical and nonmedical integrative and complementary medical practitioners.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- INTLV1.1 Demonstrate ability to deal with unreasonable requests and set limits for patients during consultations.

### 2. Applied professional knowledge and skills

- INTLV2.1 Demonstrate how to develop a management plan for patients with chronic and complex illnesses, where appropriate, by incorporating integrative into conventional medicine.
- INTLV2.2 Identify and manage important interactions and side effects (common and/or severe) associated with complementary medicines and therapies.

### 3. Population health and the context of general practice

- INTLV3.1 Refer important interactions and side effects (common and/or severe) associated with complementary medicines and therapies.

### 4. Professional and ethical role

- INTLV4.1 Apply ethical principles to more complex clinical situations involving integrative and complementary medicines.

### 5. Organisational and legal dimensions

- INTLV5.1 Describe the legislative requirements and regulations regarding complementary medicines.
- INTLV5.2 Identify presentations requiring more intensive or specialised integrative medical management.
- INTLV5.3 Understand the medicolegal and indemnity issues related to the use of complementary medicine.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

INTLC1.1 Demonstrate regular review of gaps in communication skills in integrative medicine.

### 2. Applied professional knowledge and skills

INTLC2.1 Review professional knowledge areas in integrative medicine, especially around advances in complementary medicines.

INTLC2.2 Review the need for any ongoing educational activities in integrative medicine.

INTLC2.3 Outline the role of the RACGP National Faculty of Specific Interest – Integrative Medicine.

### 3. Population health and the context of general practice

INTLC3.1 Demonstrate regular review patterns of complementary medicine use.

### 4. Professional and ethical role

INTLC4.1 Reflect and act on professional development needs in integrative medicine including QI&CPD activities.

### 5. Organisational and legal dimensions

INTLC5.1 Demonstrate regular review of links with integrative and complementary medicine practitioners.

INTLC5.2 Demonstrate regular review of medicolegal and indemnity requirements for integrative and complementary medicines.

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## *Quality and safety*

### **Contents**

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Definition	483
Curriculum in practice	483
Rationale and general practice context	484
Training outcomes of the five domains of general practice	487
Learning objectives across the GP professional life	490
<i>Medical student</i>	490
<i>Prevocational doctor</i>	491
<i>Vocational registrar</i>	492
<i>Continuing professional development</i>	493
References	494

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## Definition

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Quality in healthcare means the best possible health outcomes given the available circumstances and resources, consistent with patient centred care.<sup>1</sup>

Safety in healthcare is reducing the risk of unnecessary harm to an acceptable minimum level.<sup>2</sup> Patient safety is the freedom from hazards due to medical care or medical error in the general practice setting and is considered to be one of the dimensions of the quality framework for general practice.<sup>3</sup> Harm can arise in healthcare, by omission or commission, and from the environment in which the healthcare is carried out.<sup>3</sup>

In reality, the total absence of harm in the healthcare setting is unachievable and so the concept of safety relates to reducing the risk of unnecessary harm to an acceptable minimum level. An acceptable minimum level refers to the level of risk that is generally acceptable given the level of current knowledge, available resources and the context in which care is delivered weighed against the risk of having or not having treatment.

Systemic errors are based on the concept that although individuals make errors, characteristics of the systems within which they work can make errors more likely. Error inquiry in patient safety then focuses on circumstances rather than on operator characteristics. More errors are likely to be eliminated by focusing on systems than on individuals.<sup>2</sup>

Quality and safety initiatives in general practice often involve quite complex terminology and consistent use of language is required to enable constructive approaches to gaining skills in this area. This curriculum uses patient safety terms and language consistent with the World Health Organization and the taxonomy of the World Alliance for Patient Safety,<sup>2</sup> the Australian Commission on Safety and Quality in Health Care and the RACGP *Standards for general practices*.<sup>4</sup>

## Curriculum in practice

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The following case illustrates how the quality and safety curriculum applies to general practice:

- Linda, 32 years of age, had a skin lesion removed from her back 6 months ago by a locum GP. She who now presents for a repeat prescription of the oral contraceptive pill. You notice that she has not been back since removal of the lesion. She explains that she had to urgently visit a family member interstate a few days after the lesion was removed, but that she has been well. You notice that the histology of the lesion was a malignant melanoma and realise that Linda has not received this result.

## Rationale and general practice context

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### Quality improvement in general practice

Quality improvement is an essential general practice activity that involves examining practice structures, systems and clinical care. Improvement needs to be based on evidence produced by the practice's own data. This data can be gathered from patient or staff feedback, an audit of clinical databases or the analysis of near misses and mistakes.<sup>2</sup>

The challenge of quality in general practice is demonstrated by the gap between what is known to be best practice care and the delivery of care (outside of patient factors and healthcare costs).<sup>3</sup>

Quality improvement focuses on the growing body of knowledge relating to effective quality improvement strategies within the general practice setting,<sup>3</sup> as detailed in the RACGP Quality Framework for Australian General Practice.<sup>3</sup>

The quality framework aims to improve quality in Australian general practice by incorporating the four levels of the general practice system of care:

- the individual general practitioner at the consultation level
- the setting of this care
- the regional level
- the national level.

The framework is then divided into the six main areas that influence quality in general practice:

- capacity
- competence
- finance
- knowledge and information management
- patient focus
- professionalism.

This framework provides a regulatory setting for quality improvement in general practice. Quality improvement processes are an increasingly important aspect of practice management processes and GPs need to be familiar with the key principles of quality improvement and its implementation.<sup>3</sup>

### Patient safety

Although patient safety is only one aspect of quality improvement for general practice, it has been identified as an emerging core competency for GPs.<sup>5</sup> Patient safety incorporates all the elements that can contribute to an adverse event during the provision of healthcare.

Safety covers events ranging from harm caused as a result of a wrong clinical procedure or decision, to the adverse effects of drugs, hazards posed by medical devices, substandard products, human shortcomings or system errors. These events may occur in hospital settings, primary healthcare clinics, nursing homes, pharmacies, patients' homes and in clinical trials.<sup>6</sup>

General practice can involve many invasive procedures, from seemingly simple actions such as immunisation to more complex tasks such as major skin flap surgery. Many of these activities can be subject to error which can result in patient harm. Because of this, there is a range of patient safety knowledge and skills across many general practice activities and contexts, such as the ability to identify causes of lapses in safety and processes for ensuring the correct procedure is done at the correct site on the correct patient.<sup>7</sup>

Patient safety is achieved primarily through the development and implementation of strategies that reduce the risk of events that could cause harm to patients. Practices need to engage in quality

improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care.<sup>2</sup>

Collecting, classifying and aggregating data and information about these events, particularly with regard to preventive, mitigating and recovery strategies, is a central part of the process of improving patient quality and safety. Classification of patient safety data requires universal agreement and understanding of key terms and concepts as well as a standardised method for examining data.<sup>2</sup>

Although by international standards the quality of Australian general practice is generally high, the risk of harm to patients, health workers, general practice organisations and their patient communities are always present.

Research into the frequency and nature of error in primary healthcare has produced mixed findings.<sup>8</sup> This may be due to the different methods of collecting data about adverse events leading to differences in reported rates.<sup>9</sup> However, incident monitoring techniques can be successfully applied to Australian general practice. These techniques could facilitate the identification of factors that contribute to adverse events, and facilitate development of preventive interventions.<sup>10</sup>

Factors that influence safety and quality in general practice can be seen as a combination of personal, contextual and task-dependent factors,<sup>11</sup> suggesting the need for GPs to assess the risk attributed to clinicians, systems and patients.<sup>12</sup> Although patients are usually seen as passive (ie. as the victims of error), there is considerable scope for them to play an active role in ensuring that their healthcare is appropriate, thereby preventing mistakes<sup>13</sup> and providing feedback to practice systems to improve general practice quality.<sup>4</sup>

## Effective communication

The importance of effective and open communication is a common theme in research about patient safety. Communication errors are reported to be the leading causes of patient harm. Communication occurs at a number of levels and can be verbal or written. The presence of effective communication tools such as briefings, handover, good record keeping, patient information materials and checklists and behaviours such as clinician assertiveness can reduce the rate of harm.<sup>14</sup>

Poor communication after an adverse event (not just the original injury), can determine the decision to take legal action. Concern about the standards of care, the need for an explanation, compensation and the belief that staff and organisations should be accountable, are emerging as reasons for litigation.<sup>15</sup>

## The systems approach to quality and safety

Research suggests that adverse events related to medicines are common in primary healthcare,<sup>16</sup> that medication errors are widely distributed among doctors and that a reduction in medication errors requires a systems approach.<sup>17</sup>

Although there is a tendency for healthcare team members to define error as a breach of standards by an individual,<sup>18</sup> a systems approach that identifies contributing factors in the environment and builds defences against potential harm, regardless of the cause, is more appropriate. This approach takes a complementary role to competence in the individual.<sup>19</sup> Members of high performing teams generally have a clear understanding of their roles, and the demands on other team members, and work within a climate of openness and trust where team leaders are receptive to alternate views.<sup>20</sup>

Risk management in the healthcare system involves all levels of an organisation and is concerned with the creation and maintenance of safe systems of care.<sup>21</sup> Systems utilised by the primary healthcare provider will vary, but may include tools such as monitoring and reporting, practice system audits, recall systems, incident logging and relevant continuous professional development activities.<sup>7</sup>

Promoting a culture of safety and quality in healthcare settings is one of the pillars of the safety and quality movement. A patient safety culture recognises the inevitability of error and actively seeks to create safeguards for patients.<sup>22</sup>

Quality improvement requires a collaborative effort of all general practice staff, and staff need to feel

empowered to contribute to quality and safety.<sup>4</sup>

Consistent use of risk management systems helps reduce clinical risk and ensures that practice errors are identified and processes improved to reduce the likelihood of recurrence.

The journey of general practice can mean that as workplace situations and patient populations change, some knowledge and skills are enhanced, while other areas are diminished. This emphasises the role for ongoing vigilance of self and others in relation to competence, performance and maintaining the ability to refer appropriately. Advances in the 'science' of general practice, such as new medicines, new technology and improved evidence about efficacy and effectiveness, also mean that the risks to patients change. Therefore, key workplace attitudes that foster general practice patient safety promote:

- a just, supportive and transparent culture
- skills and knowledge in error awareness
- a systems approach.

## Clinical governance and clinical leadership

Clinical governance and clinical leadership, as described in the *Practice management* curriculum statement, are central to reform in the areas of quality and safety.<sup>4</sup> Refer to this statement when undertaking education in quality and safety.

## Related curriculum areas

Patient safety affects all areas of health, but curriculum statements of direct relevance to patient safety are:

- *Critical thinking and research*
- *Doctors' health*
- *Multidisciplinary care*
- *Practice management*
- *Procedural skills*
- *Quality use of medicines.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- QAST1.1** Use effective communication, active listening skills, self awareness and self reflection to assess external and internal influences to help reduce hazards to patient safety.
- QAST1.2** Use patient communication skills to acknowledge the experience that patients bring to their care, such as their knowledge about their symptoms and treatments.
- QAST1.3** During communication and patient management, recognise that patients can take an active role in patient safety, sometimes helping to detect errors and adverse events, which may alert doctors to the presence of risk.
- QAST1.4** Acknowledge patient concerns and complaints about treatments and the general practice when promoting patient safety.
- QAST1.5** Use effective skills to discuss adverse events with patients and peers that aim to identify causes and prevent recurrence.

## 2. Applied professional knowledge and skills

- QAST2.1** Understand the Quality Framework for Australian General Practice and implementation strategies in the general practice setting.
- QAST2.2** Understand that changes in the person (eg. change in cognitive state), the patient healthcare context (eg. the emergence of new diseases) and in the nature of clinical care (eg. advances in technology) all create changes that may increase the likelihood of harm to patients. This requires ongoing vigilance to minimise the impact of these changes on clinical care.
- QAST2.3** Apply knowledge of the impact of human factors, such as the role of cognitive overload and resilience, in order to maximise the safety of patients.
- QAST2.4** Apply knowledge and use processes to ensure that the correct patient receives the correct treatment or procedure in the general practice setting and that they are compatible with those used in the acute health setting.
- QAST2.5** Recognise and manage adverse outcomes including adverse events and near misses in patient care.
- QAST2.6** Understand the characteristics of effective teams and the skills needed to develop and sustain these teams are a core element of ensuring a systemic approach to patient safety and quality improvement.
- QAST2.7** Apply knowledge and skills in the identification of the causes of near misses and adverse events to reduce risk of harm that reflects the Australian general practice setting.
- QAST2.8** Apply skills and knowledge necessary to undertake both quality assurance and quality improvement activities that include reducing the risk of adverse events.

## 3. Population health and the context of general practice

- QAST3.1** Understand the local, regional and national factors that affect quality improvement in the general practice setting.
- QAST3.2** Know the epidemiology of harm and error, eg. common causes of harm and how this can focus attention on the most effective interventions for reducing risk of harm to patients.

- QAST3.3 Identify factors that affect the capacity of patients to engage in reducing risk of harm so that care and patient safety measures can be tailored accordingly. For example, legal competence of patients and their views of medical care and the authority of doctors.
- QAST3.4 Use a range of ways to explain risk to assist the difficulty that patients may have when trying to understand the magnitude, likelihood and impact of the risks they face in their healthcare. This includes adapting risk explanations to people from culturally and linguistically diverse backgrounds.
- QAST3.5 Understand how general practice advocacy at a health system level helps protect the safety of patients, eg. by alerting manufacturers to design limitations (eg. poor packaging) or by ensuring that the health system is not a barrier to patient safety (eg. the impact of workforce numbers on safe general practice care).

## 4. Professional and ethical role

- QAST4.1 Apply legal and ethical requirements for obtaining informed consent from patients and carers, including the impact and implications of competence in decision making, and to advance decision making (including advance care planning and health directives).
- QAST4.2 Provide feedback on performance to all members of the general practice team to help maintain the safety of patients including engaging with peers, team members and other providers about issues such as competence. Undertake steps to protect patients from related factors that may cause harm.
- QAST4.3 Understand how the principles of natural justice and procedural fairness can help when investigating patient safety issues.
- QAST4.4 Seek feedback from patients, general practice peers and team members and act on this feedback to help promote a safer patient environment.
- QAST4.5 Document processes and procedures such as triage arrangements and quality improvement processes that help promote patient safety.
- QAST4.6 Undertake quality assurance and quality improvement activities which reduce the likelihood of harm to patients.

## 5. Organisational and legal dimensions

- QAST5.1 Understand that systems based approaches to health that focus on quality and safety is likely to produce a safer health care environment, thus complementing the person based approach.
- QAST5.2 Understand the implementation of the Quality Framework for Australian General Practice into the general practice setting.
- QAST5.3 Communicate effectively with members of the general practice team to ensure continuity of information to optimise patient care and protect patient safety.
- QAST5.4 Engage with members of the general practice team in briefings before, and where necessary, debriefings after procedures with which team members assist.
- QAST5.5 Accurately record clinical encounters with patients to ensure the continuity of safe, high quality patient care, and to help resolve any adverse outcomes.

- QAST5.6 Understand that the development of an open, transparent, supportive and just culture within the general practice setting is regarded as the foundation of safety for patients and members of the healthcare team.
- QAST5.7 Facilitate teamwork and demonstrate both leadership and the ability to take direction and work within teams when necessary.
- QAST5.8 Report on incidents including lapses in safety, slips, errors, mistakes, adverse events and near misses within the practice.
- QAST5.9 Assist the cultivation of meaningful and timely ways of reporting and acting on incident reports.
- QAST5.10 Report errors appropriately to organisations outside the practice such as medical indemnity insurers, companies for equipment failures, and agencies such as adverse drug reporting authorities.
- QAST5.11 Understand general practice legal obligations (including those relating to medical indemnity insurers), especially in the context of the discussion of adverse events.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- QASLM1.1 Describe internal cues and thought processes that might facilitate or impede the patient-doctor relationship.
- QASLM1.2 Identify factors that contribute to distracting the GP during patient care tasks.
- QASLM1.3 Outline occasions when a patient might contribute to maintaining the safety of care.

### 2. Applied professional knowledge and skills

- QASLM2.1 Define a near miss and adverse event.
- QASLM2.2 Outline characteristics of effective teams.
- QASLM2.3 List common factors that are causes of error in medical practice.
- QASLM2.4 Outline the concept of quality healthcare and strategies for improvement.

### 3. Population health and the context of general practice

- QASLM3.1 Describe common forms of harm to patients in medical practice.
- QASLM3.2 List examples of factors that may impede a patient making a realistic assessment of their risk.

### 4. Professional and ethical role

- QASLM4.1 Describe the elements of valid consent.
- QASLM4.2 Describe factors that would facilitate discussion of patient safety among peers.
- QASLM4.3 Describe the concept of 'professional boundaries'.
- QASLM4.4 Describe the symptoms of stress and fatigue and apply these to the workplace.

### 5. Organisational and legal dimensions

- QASLM5.1 Describe a clinician's patient safety related legal obligations to their medical registration board and medical indemnity insurer.
- QASLM5.2 Outline the difference between a 'person based' and a 'systems based' approach to patient safety.
- QASLM5.3 Discuss the implementation of quality improvement of healthcare systems.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge — medical student

### 1. Communication skills and the patient-doctor relationship

- QASLP1.1 Describe internal cues that occur during a clinician's interactions with patients.
- QASLP1.2 Distinguish patient related factors that are likely to impede effective communication.
- QASLP1.3 Differentiate between an effective handover of clinical care from an ineffective handover.

### 2. Applied professional knowledge and skills

- QASLP2.1 Differentiate between a near miss and an adverse event.
- QASLP2.2 Explain why the distinction between near misses and adverse events is important.
- QASLP2.3 Distinguish between effective leadership and the ability to take direction and work within teams when necessary.
- QASLP2.4 Outline quality improvement settings within your current workplace setting.

### 3. Population health and the context of general practice

- QASLP3.1 Describe common causes of harm to patients in hospital and how this may differ from the general practice setting.

### 4. Professional and ethical role

- QASLP4.1 Distinguish between appropriate and inappropriate boundaries in patient relationships.
- QASLP4.2 Outline ways of gaining feedback from patients in the general practice setting.
- QASLP4.3 Describe how to give constructive feedback on performance to other members of the team.
- QASLP4.4 Outline the principles of natural justice and procedural fairness.

### 5. Organisational and legal dimensions

- QASLP5.1 Differentiate between a just and unjust culture.
- QASLP5.2 Describe examples of a positive contribution to creating a 'safety culture' and their application to the current workplace.
- QASLP5.3 Identify the symptoms of stress and fatigue and apply these to the workplace.
- QASLP5.4 Outline quality assurance processes and how these apply in the hospital setting.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge — prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- QASLV1.1 Demonstrate effective communication in the patient-doctor relationship.
- QASLV1.2 Explain effective ways to manage complaints by patients.
- QASLV1.3 Demonstrate effective strategies to raise concerns with a colleague about a lapse in safety.
- QASLV1.4 Explain the issues involved in discussing an adverse event with patients.

### 2. Applied professional knowledge and skills

- QASLV2.1 Outline the Quality Framework for Australian General Practice and strategies for implementation in the general practice setting.
- QASLV2.2 Complete a structured and systematic analysis of the causes of a near miss or adverse event.
- QASLV2.3 Arrange a quality improvement activity focused on improving practice processes.

### 3. Population health and the context of general practice

- QASLV3.1 Outline the relevant laws relating to competence in decision making for minors and for adults.
- QASLV3.2 Show how the magnitude, likelihood and impact of risk can be explained to patients with poor literacy skills.
- QASLV3.3 Outline the regulatory framework for quality improvement in the general practice setting.

### 4. Professional and ethical role

- QASLV4.1 Describe processes for maintaining appropriate boundaries in patient-doctor relationships.
- QASLV4.2 Apply the concept of procedural fairness to a complaint about a colleague.
- QASLV4.3 Explain the ethical issues that arise in a discussion about an adverse event caused in another health setting.
- QASLV4.4 Describe the role of clinical governance and clinical leadership in quality improvement measures including patient safety.

### 5. Organisational and legal dimensions

- QASLV5.1 Describe the human factors of risk and provide a range of safeguards in the general practice setting which protect against these.
- QASLV5.2 Explain how safeguards to patient safety operate within the systems of the practice.
- QASLV5.3 Demonstrate effective recording of clinical encounters with patients.
- QASLV5.4 Identify and modify organisational risks to patient safety.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge — vocational doctor

### 1. Communication skills and the patient-doctor relationship

- QASLC1.1** Demonstrate the ability to modify communication processes about risks and benefits for the individual context of each patient.
- QASLC1.2** Create checklists for briefing and debriefing for new or uncommon procedures.
- QASLC1.3** Formulate ways to explain new technologies or treatments to patients.

### 2. Applied professional knowledge and skills

- QASLC2.1** Assess areas where clinical competence diminishes and create safeguards against harm to patients.
- QASLC2.2** Modify plans to accommodate cognitive overload, fatigue and stress in the practice team.
- QASLC2.3** Create opportunities to recognise and reward quality initiatives in the practice setting.

### 3. Population health and the context of general practice

- QASLC3.1** Document the reporting of lapses in quality to external agencies, such as medical indemnity insurers and post-marketing surveillance bodies such as the Therapeutics Goods Administration and Australian Drug Reactions Advisory Committee.
- QASLC3.2** Monitor trends in near misses and adverse events in the general practice setting.
- QASLC3.3** Modify processes in line with advances in the evidence of effective clinical practice.

### 4. Professional and ethical role

- QASLC4.1** Plan clinical discussions with peers in order to learn from ongoing practice.
- QASLC4.2** Integrate patient feedback into ongoing professional development.
- QASLC4.3** Maintain clinical competencies through continuing professional development and quality improvement activities.

### 5. Organisational and legal dimensions

- QASLC5.1** Integrate enhanced safeguards for patients into the organisational processes of the general practice.
- QASLC5.2** Integrate contingency planning into general practice planning.
- QASLC5.3** Assess risk in the practice setting on a consistent basis.
- QASLC5.4** Describe, where appropriate, the quality improvement measures within the practice.
- QASLC5.5** Outline regulatory frameworks that govern quality improvement within the general practice setting.

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## *Practice management*

### **Contents**

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Definition	499
Curriculum in practice	499
Rationale and general practice context	500
Training outcomes of the five domains of general practice	502
Learning objectives across the GP professional life	503
<i>Medical student</i>	503
<i>Prevocational doctor</i>	505
<i>Vocational registrar</i>	507
<i>Continuing professional development</i>	509
References	511

**The Royal Australian College of General Practitioners  
Curriculum for Australian General Practice 2011**

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## Definition

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Practice management involves decisions, actions and resource allocation to enable the provision of professional services to meet the objectives of the organisation.

The management of a medical practice requires understanding of the needs of the health professionals, patients, nonmedical staff and the community.<sup>1,2</sup> Management processes involve planning, finance, technology application, information and, most importantly, people.<sup>2</sup>

## Curriculum in practice

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The following case illustrates how the practice management curriculum applies to general practice:

- Jackie is a talented and enthusiastic GP who moved to a small town over a year ago. She quickly developed a busy practice and now finds she works longer hours than she would like. Her appointments are booked out 3 weeks in advance so people who are acutely unwell must be fitted in on top of an already heavy schedule. Consequently, Jackie regularly misses lunch and does not arrive home until after dark, by which time she feels too tired to walk her dog. Jackie works as a solo GP because she did not feel comfortable joining the other practice in town that has two older doctors, which meant she would be on call every night. She has a high number of pensioners whom she bulkbills. She knows she should be doing more care plans and health promotion work but doesn't have the time. She doesn't employ a nurse, but does have a great practice manager who also works at the front desk as a receptionist. Jackie needs a holiday, but can't afford to pay a locum as her cost structures and overheads are 80% of her income. She is feeling that it is getting too difficult to stay in the town.

## Rationale and general practice context

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The effective delivery of healthcare to patients and the community depends on efficient practice management systems that address the needs of patients, the community and health professionals in a balanced, responsive and cost effective way.

### GPs as managers

Involvement in management is not confined to practice owners and practice managers, but also requires the participation of all persons in the practice. General practitioners, as health professionals, need to learn and apply management knowledge and skills to ensure the best outcomes for their patients and themselves.

This role of GPs as managers is becoming an increasingly important part of general practice training in relation to practice management and health needs of the community due to:

- the increasing move toward more multidisciplinary team community based care
- workforce shortages
- evolving funding arrangements of healthcare
- evolving health information management in the context of rapidly expanding e-health processes
- the application and accreditation of quality management principles, evidence based management and risk management to all areas of practice management.

Organisational skills are the foundation of good practice management. While management skills have traditionally not taken a high role in medical education, they are essential to ensuring the viability of high quality general practice services and, therefore, the cornerstone of the Australian health system. While many individual issues require attention for effective practice management, they can be grouped into areas of financial management, working with people, managing facilities, practice quality and safety and information management.

Practice management provides the medium for clinical practice and is a significant determinant in successful health outcomes. The application of practice management occurs across the five domains of general practice, and is critical in the working life of the GP and needs to be sensitive to the context of general practice. Wherever a clinical activity occurs there is a management activity occurring in tandem. For example, performing a Pap test requires a range of management activities including the provision of facilities and equipment, couriers for slides, information management, recall systems and staff.

General practitioners need to effectively manage their professional role as a medical practitioner and organisational role as a member of a general practice, regardless of whether they have an ownership or an employee role.

General practitioners are increasingly working as part of a multidisciplinary general practice team, presenting new challenges to practice management. Human resource management will become more complex including processes associated with recruitment and ongoing staff management.

General practitioners practice in a range of clinical situations and the management processes involved will vary according to the setting. To enable all doctors to fulfil their clinical role, knowledge of management is needed. Further understanding is required for GPs who are running their own practice compared to being an employee GP.

## Clinical governance and GPs as clinical leaders

Health reforms in quality and safety mean there is an increasing role in clinical governance. The RACGP has defined this as a framework for clinicians and health service managers to be jointly accountable for patient safety and quality care.<sup>1</sup>

Clinical leaders are appointed within a practice to help implement clinical governance through their role of:

- being responsible for safety and quality improvement systems within the practice
- ensuring accountability of all staff involved in monitoring and improving care and services
- developing a problem solving multidisciplinary team systemic approach that promotes a climate of safety and quality.

The skills required for GPs to be clinical leaders include ongoing education, the use of clinical audits, implementing clinical effectiveness, managing risk, research and development, and promoting openness of management.<sup>1</sup>

Clinical leaders need to understand their roles and responsibilities<sup>1</sup> as part of their practice management training.

## Related curriculum areas

Refer also to the curriculum statements:

- *E-health* for electronic support of practice management
- *Procedural skills*
- *Quality and safety* for educational implications for practice management.

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- PMAT1.1 Communicate clearly with patients and their carers with respect to practice operational procedures such as opening times, access to after hours services and home visits, and costs and billings.
- PMAT1.2 Identify and overcome potential barriers to communicating practice procedures, for example, in patients with disabilities, young people and patients from linguistically and culturally diverse backgrounds.

## 2. Applied professional knowledge and skills

- PMAT2.1 Apply the regulations that affect the business of general practice which are essential for effective patient management.

## 3. Population health and the context of general practice

- PMAT3.1 Have an overall knowledge of the special characteristics of the Australian health system, how general practice operates within this environment and how this influences Australian practice management practice processes, including special issues relating to the local community.

## 4. Professional and ethical role

- PMAT4.1 Understand the role of clinical and practice governance.
- PMAT4.2 Know the ethical and legal considerations that influence all practice management processes.
- PMAT4.3 Balance work-life issues when operating practices to ensure successful management of professional and personal issue.
- PMAT4.4 Understand clearly the roles, responsibilities and skill sets required of general practitioners working within multidisciplinary and practice teams.
- PMAT4.5 Understand the roles, responsibilities and skill sets required to be a clinical leader.

## 5. Organisational and legal dimensions

- PMAT5.1 Know the organisational skills required for ensuring successful and viable high quality general practice services.
- PMAT5.2 Know the principles of effective practice management including:
- PMAT5.2.1 financial management
  - PMAT5.2.2 working with people
  - PMAT5.2.3 managing facilities
  - PMAT5.2.4 practice quality and safety
  - PMAT5.2.5 information management
  - PMAT5.2.6 clinical governance.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- PMALM1.1 Describe the importance of communicating practice policies and procedures, such as appointment booking to patients and community.
- PMALM1.2 Discuss the barriers to effective communication regarding practice operating procedures to patients with disabilities, young people and those from culturally and linguistically diverse backgrounds.
- PMALM1.3 Describe the importance of communication skills for patient service delivery, including dealing with complaints.

### 2. Applied professional knowledge and skills

- PMALM2.1 Identify regulations that apply to medical practitioners and their implications for professional practice.
- PMALM2.2 Describe the essential features of medical practice legislation, codes and guidelines that affect Australian jurisdictions.
- PMALM2.3 Describe the difference between an employee and contractor.
- PMALM2.4 Describe the management roles and responsibilities of a practice owner.

### 3. Population health and the context of general practice

- PMALM3.1 Describe the healthcare system in Australia and contrast this with international examples.
- PMALM3.2 Describe and contrast public and private healthcare in Australia.
- PMALM3.3 Outline the compensation programs for work and traffic injuries.

### 4. Professional and ethical role

- PMALM4.1 Discuss the Australian Medical Association (AMA) Code of Ethics Statement in practice management.
- PMALM4.2 Explain the role of business ethics in a medical practice.
- PMALM4.3 Describe and compare stages of a medical career.
- PMALM4.4 Analyse issues relating to balancing professional and personal life.

## 5. Organisational and legal dimensions

- PMALM5.1 Outline patient billing in general practice including private fees, bulk-billing and third party payments.
- PMALM5.2 Describe the major costs in operating a general practice and provide examples of how these can be controlled.
- PMALM5.3 List and describe job roles in a solo and group general practice.
- PMALM5.4 Describe and provide examples of GPs working in a health team.
- PMALM5.5 Describe and compare the role of a GP in the community with the role of medical specialists in a hospital.
- PMALM5.6 Describe the infrastructure needs for general practice.
- PMALM5.7 Outline basic principles of quality management.
- PMALM5.8 Give examples of medical risk and business risk in general practice.
- PMALM5.9 Understand processes for managing information in general practice, including health and business information.
- PMALM5.10 Explain regulations relating to health information and their application.
- PMALM5.11 Describe how health information is recorded and used.
- PMALM5.12 Describe the use of patient recall systems.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- PMALP1.1 Demonstrate effective communication of hospital, institutional or organisation operating policies and procedures such as appointment booking to patients.
- PMALP1.2 Demonstrate effective skills for overcoming barriers to communicating hospital, institutional or organisational practice operating procedures to patients such as patients with disabilities, young people and people from culturally and linguistically diverse backgrounds.
- PMALP1.3 Outline communications skills required for dealing with complaints in the hospital, institutional or organisational setting.

### 2. Applied professional knowledge and skills

- PMALP2.1 Describe the complex interaction between the healthcare environment, patient and doctor.
- PMALP2.2 Outline how physical or cognitive disability can limit access to healthcare services.
- PMALP2.3 Describe legal/institutional requirements for health records.
- PMALP2.4 Outline the role of the health record in continuity of care.
- PMALP2.5 Outline how time management affects patient care and hospital function.
- PMALP2.6 Demonstrate an ability to prioritise daily workload, including demonstrating punctuality in the workplace.
- PMALP2.7 Demonstrate an appropriate standard of professional practice and work within personal capabilities.
- PMALP2.8 Explain the principles of medical triage.
- PMALP2.9 Outline the elements of effective discharge planning (eg. early, continuous, multidisciplinary).
- PMALP2.10 Follow organisational guidelines to ensure smooth discharge.

### 3. Population health and the context of general practice

- PMALP3.1 Describe the legal requirements in patient care (eg. mental health legislation, death certification, prescribing laws).
- PMALP3.2 Complete medicolegal documentation appropriately.
- PMALP3.3 Liaise with legal and statutory authorities.
- PMALP3.4 Demonstrate compliance with informing authorities of notifiable diseases.
- PMALP3.5 Describe logistic processes of disease outbreak management.
- PMALP3.6 Outline the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS).

## 4. Professional and ethical role

- PMALP4.1 Describe and demonstrate respect for the roles and responsibilities of team members.
- PMALP4.2 Participate fully in teams, recognising that teams extend outside the hospital (eg. GPs).
- PMALP4.3 Demonstrate preparedness to adopt a range of roles within a team.
- PMALP4.4 Understand the characteristics of effective teams.
- PMALP4.5 Demonstrate an ability to work with others and resolve conflicts when they arise.
- PMALP4.6 Demonstrate flexibility and preparedness to change.
- PMALP4.7 Outline the leadership role that may be required of a doctor.
- PMALP4.8 Show an ability to work well with others and lead them.
- PMALP4.9 Outline the skills of a good leader.
- PMALP4.10 Reflect on personal experiences, actions and decision making.
- PMALP4.11 Outline the ethical complexity of medical practice, and follow professional and ethical codes.
- PMALP4.12 Demonstrate consultation with colleagues about ethical concerns.
- PMALP4.13 Accept responsibility for ethical decisions.
- PMALP4.14 Outline the personal health risks of medical practice such as fatigue and stress.
- PMALP4.15 Maintain personal health and wellbeing.
- PMALP4.16 Recognise the potential risk to others from your own health status.

## 5. Organisational and legal dimensions

- PMALP5.1 Identify the different types of healthcare teams (eg. resuscitation team and multidisciplinary stroke team including patient and carer team members where possible).
- PMALP5.2 Demonstrate respect for the leadership role within a team, such as nurse unit manager and trauma resuscitation leader.
- PMALP5.3 Demonstrate provision of access to culturally appropriate healthcare.
- PMALP5.4 Describe the harm caused by errors and system failures.
- PMALP5.5 Document and report adverse events in accordance with local incident reporting systems.
- PMALP5.6 Demonstrate recognition and management of adverse events and near misses.
- PMALP5.7 Demonstrate consultation with colleagues about ethical concerns.
- PMALP5.8 Demonstrate acceptance of responsibility for ethical decisions.
- PMALP5.9 Outline the personal health risks of medical practice such as fatigue and stress.
- PMALP5.10 Outline measures for maintaining personal health and wellbeing.
- PMALP5.11 Recognise the potential risk to others from your own health status.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- PMALV1.1 Demonstrate effective communication of practice operating policies and procedures such as appointment booking, to patients and community in the general practice and community based setting.
- PMALV1.2 Demonstrate effective skills for overcoming barriers to communicating practice operating procedures to patients with disabilities, young people and those from culturally and linguistically diverse backgrounds in the general practice and community based setting.
- PMALV1.3 Outline communications skills required for dealing with complaints in the general practice and community based setting.

### 2. Applied professional knowledge and skills

- PMALV2.1 Discuss regulations that apply to medical practitioners and their implications for professional practice including business regulations in a medical practice context, including the Trade Practices Act, occupational health and safety regulations and equal employment opportunity legislation.

### 3. Population health and the context of general practice

- PMALV3.1 Outline general practice models of service delivery.
- PMALV3.2 Identify community agencies and health practitioners and describe their relationship with local GPs.
- PMALV3.3 Explain health insurance to patients.
- PMALV3.4 Use and interpret MBS, PBS and government funding programs as they apply to general practice, including Practice Incentive Payments (PIP), Service Incentive Payments (SIP) and other blended payments.

### 4. Professional and ethical role

- PMALV4.1 Describe the management roles and responsibilities of a practice owner.
- PMALV4.2 Describe features of good practice governance.
- PMALV4.3 Describe features of good clinical governance.
- PMALV4.4 Discuss and evaluate activities that improve personal wellbeing.
- PMALV4.5 Describe the process of assessing a practice to join, or purchase, in relation to personal needs.
- PMALV4.6 Define clearly the roles, responsibilities and skill sets required of GPs working within multidisciplinary and practice teams.

## 5. Organisational and legal dimensions

- PMALV5.1 Outline the processes involved in employing people in general practice.
- PMALV5.2 Describe and demonstrate processes for developing and leading people in a practice.
- PMALV5.3 Describe and compare different costing and billing practices.
- PMALV5.4 Manage and develop relationships with team colleagues.
- PMALV5.5 Describe and use negotiation skills.
- PMALV5.6 Employ conflict resolution skills with patients and staff.
- PMALV5.7 Outline the use of motivation and goal setting.
- PMALV5.8 Explain the important elements of infrastructure design and maintenance in general practice.
- PMALV5.9 Describe equipment maintenance requirements for general practice.
- PMALV5.10 List insurance requirements in general practice.
- PMALV5.11 Describe security measures in general practice for provider identifying information such as prescriptions, provider and prescriber numbers.
- PMALV5.12 Analyse and evaluate risk in general practice and strategies for managing risk.
- PMALV5.13 Describe the role and summarise the content of RACGP *Standards for general practices*.
- PMALV5.14 Describe the quality improvement process in general practice. For example, outline the PDSA (plan, do, study, act) cycle.
- PMALV5.15 Compare customer service in a general practice to the retail sector.
- PMALV5.16 Respond to, and resolve, patient complaints.
- PMALV5.17 Identify high risk areas for adverse patient outcomes in general practice.
- PMALV5.18 Compare paper and electronic health information management.
- PMALV5.19 Consider issues of back up, database integrity and security (eg. virus protection).
- PMALV5.20 Use patient recall systems and risk management procedures.
- PMALV5.21 Identify critical business information systems in general practice.
- PMALV5.22 Identify information sources for a general practice.
- PMALV5.23 Outline practice continuity planning requirements.
- PMALV5.24 Describe the different legal forms of practice especially in regard to liability including company, partnership, associateships and trusts.
- PMALV5.25 Describe the legal and ethical responsibilities that an employer has to their staff.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

PMALC1.1 Review communication skills required for the effective delivery of general practice services.

### 2. Applied professional knowledge and skills

PMALC2.1 Review level of required professional knowledge areas in practice management, especially business requirements.

PMALC2.2 Demonstrate, when appropriate, that clinical leadership skills are current.

### 3. Population health and the context of general practice

PMALC3.1 Demonstrate optimisation of patient care systems to utilise special funding and access arrangements for patients.

### 4. Professional and ethical role

PMALC4.1 Evaluate and implement practice governance activities.

PMALC4.2 Formulate a professional development plan.

PMALC4.3 Assess strategies for marketing professional services.

PMALC4.4 Evaluate the role of public relations activities in general practice.

PMALC4.5 Develop a succession plan.

PMALC4.6 Identify and develop the clinical leader(s) in your practice.

### 5. Organisational and legal dimensions

PMALC5.1 Analyse and evaluate a business strategy.

PMALC5.2 Measure practice performance.

PMALC5.3 Formulate a business plan.

PMALC5.4 Evaluate superannuation and investment strategies.

PMALC5.5 Describe financial reporting and tax compliance requirements for general practice.

PMALC5.6 Describe the use of management accounting skills in general practice.

PMALC5.7 Evaluate financing options in general practice.

PMALC5.8 Describe the process to manage change.

PMALC5.9 Describe and evaluate practice culture and recognise elements of practice culture that promote improvement and those that impede improvement.

- PMALC5.10 Develop and review policies and procedures relating to employment including job descriptions; advertising and recruitment; interviewing and selection; orientation, training; performance management and appraisal, feedback and termination.
- PMALC5.11 Evaluate facility utilisation.
- PMALC5.12 Compare financing and investment strategies in providing practice facilities.
- PMALC5.13 Meet current quality standards such as those described in the RACGP *Standards for general practices* and the RACGP *Infection control standards for office based practices*.
- PMALC5.14 Use practice audits to improve patient service and care.
- PMALC5.15 Apply continuous improvement and quality tools to improve practice activities.
- PMALC5.16 Identify and develop communication strategies and barriers that promote or impede improvements in healthcare.
- PMALC5.17 Analyse near miss and critical incidents.
- PMALC5.18 Use patient feedback to improve patient service.
- PMALC5.19 Use practice information sources including databases to improve care.
- PMALC5.20 Use practice information systems to assess practice capacity, demand and equity of care.
- PMALC5.21 Develop and use key performance indicators for achieving practice objectives.

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## *Procedural skills*

### **Contents**

---

Definition	515
Curriculum in practice	516
Rationale and general practice context	517
Training outcomes of the five domains of general practice	519
Learning objectives across the GP professional life	521
<i>Medical student</i>	521
<i>Prevocational doctor</i>	522
<i>Vocational registrar</i>	523
<i>Continuing professional development</i>	524
References	525

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## Definition

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Procedural skills encompass the areas of clinical care that require physical and practical skills of the clinician in order to accomplish a specific and well characterised technical task, or medical procedure (or just a procedure).

A procedure is a manual intervention that aims to produce a specific outcome during the course of patient care; it may be investigational, diagnostic, and/or therapeutic, and is usually able to be performed in the ambulatory primary healthcare setting thus excluding:

- manual skills which are part of routine clinical examination
- purely interpretive skills
- complex surgical procedures that require a general anaesthetic.

Inherent in the term of medical procedure is the concept of invasiveness. This may involve discomfort for the patient and a risk of adverse effects and complications associated with the procedure in addition to those associated with the medical condition which initially necessitated the procedure.

This aspect of invasiveness is not absolute, as some procedures are more invasive than others, for example, venepuncture compared with urinalysis.

Procedures may require the use of equipment which, in turn, implies the need for appropriately equipped and resourced facilities with quality control processes in place for the successful completion of the procedure.

Procedural skills requirements vary according to the context in which procedures are performed and according to the level of complexity of the required procedure. For example, general practitioners in rural and remote communities may be required to provide treatment such as emergency medicine procedures,<sup>1</sup> which entail a level of complexity different to that of their urban counterparts. The term advanced rural level skills has been developed to describe these requirements which include:

- major general surgery
- obstetrics (including management of the delivery, surgical or non surgical)
- anaesthesia (including general anaesthesia)
- orthopaedic surgery (including the management of dislocations and fractures requiring major regional or general anaesthesia)
- radiology (including personally performed X-rays, ultrasounds and/or echocardiograms with interpretation of results, not confined to limb X-rays)
- endoscopy (including colonoscopy or gastroscopy).

Procedural skill competency is the type and level of behaviour required in relation to a specific skill to achieve a successful outcome. For example, the skill competency for one procedure (eg. dipstick urinalysis) may include the ability to explain and perform the task appropriately in an unsupervised fashion. Other procedures may require just the skill to be able to explain the procedure's principles to a patient without the necessary skill for the clinician to perform the procedure themselves, for example an abdominal CT scan.

Clinicians need to be familiar with the professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

Procedural competency often involves the acquisition of specific psychomotor skills. Procedural skills training needs to provide the opportunity to perform and perfect the necessary psychomotor skills, taking into account that the acquisition of knowledge and skills takes place at an individual rate.

## Curriculum in practice

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The following presentations illustrate how the procedural skills curriculum applies to general practice:

- A 23 year old man presents for removal of genital warts
- A hearing impaired older person presents for an appointment for the surgical removal of a benign skin lesion
- Your registrar has read about a new way of establishing an emergency airway in a child and would like to see it demonstrated. How confident are you to arrange a simulation?

## Rationale and general practice context

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Procedural medicine is an integral part of Australian general practice and is becoming more common. During 2008–2009, there were 16.7 procedural events for every 100 general practice encounters. This is a significantly higher number of procedures than the 12.5 procedures per 100 patient encounters in 1999–2000.<sup>2</sup>

### Patient safety and informed consent

For many patients, a successful clinical outcome depends on having a well performed technical procedure. Therefore, technical competence is a key aspect for procedural training.<sup>3</sup> The opportunities for learning and successfully performing procedural tasks necessary for unsupervised general practice need to be balanced with concerns of patient safety, which are of the highest priority during any medical procedure.

The ability to educate and inform patients of the risks and benefits of each procedure and to ensure that informed consent is obtained is part of procedural skills competency. This includes discussing any discomfort or pain and how these will be managed.

Acquiring proficiency in procedural skills requires skills in recognising and managing associated complications.

Maximising procedural skill competencies not only helps to minimise any potential harm to patients, but may also help minimise potential medicolegal consequences. Continuing surveillance of reports from medical boards, alerts and bulletins from medical defence organisations and surveillance authorities for trends in procedural risk complications provides an important opportunity to identify and minimise adverse risk associated with medical procedures.

### Occupational health and safety

Education on the potential hazards to the health of the clinician performing the procedure and their assistant(s) is critical for the prevention and management of procedural related harm.

Clinicians and workplace managers need to be aware of their roles and responsibilities in maintaining a safe work environment during procedural tasks or procedural complications in accordance with workplace standards; for example, the safe handling of body fluids and substances, or the clinician's responsibilities regarding blood borne virus transmission and the management of needlestick injuries.

Clinicians must also recognise that psychomotor impairment or medical conditions may affect the ability to successfully and safely perform technical tasks and must act appropriately in each particular circumstance. This may require limiting participation to those tasks for which they can demonstrate competence.

### Procedural skills and the general practitioner learning life

Over the general practice learning life, varying procedural skill levels may be required.

In general, procedural skills acquired as a medical student provide a basis for procedural skill acquisition later in the learning life, although career path changes can result in significant changes in procedural skill requirements and competency levels. General practitioners need to recognise their current procedural skill requirements and ensure that the appropriate skill competency level is maintained.

Skill level requirements will often depend upon the clinical context. For example, a prevocational hospital doctor may have acquired specific procedural skills that may not be required when they commence working in an urban general practice. This lack of demand for the use of this skill may result in a diminished skill level. However, should the need arise for this clinician to practise in a remote area, they may need to undertake additional training to acquire appropriate skill competency levels.

Some general practitioners will develop special interest areas, for example, dermatology or aviation medicine, requiring a different procedural skill set in addition to that of routine general medical practice. Clinicians in these situations need to be clear on their skill requirements and the ongoing requirements for procedural skill maintenance.

Procedural skill requirements for the level of final year medical students are set by medical schools and the Australian Medical Council.<sup>4</sup>

Procedural skill requirements for prevocational doctors (first and second postgraduate year and later) are set by the Australian Curriculum Framework for Junior Doctors.<sup>5</sup>

Procedural skill requirements for general practice registrars for Fellowship are set by The Royal Australian College of General Practitioners.

General practitioners with a special interest area or undertaking additional procedural skills need to ensure that their skill levels meet the recognised standards/curriculum requirements for procedural skill competency acquisition and maintenance. Examples include:

- Standards for General Practice Education and Training Requirements for Fellowship items<sup>6</sup>
- Advanced rural skills training<sup>1</sup>
- Fellowship of Advanced Rural General Practice<sup>7</sup>
- RACGP Joint Consultative Committees<sup>8</sup>
- Other specialist medical colleges
- Other jurisdictional requirements/standards, eg. the Australian Government requirements for yellow fever vaccination providers<sup>9</sup> or RACGP guidelines for Implanon insertion.<sup>10</sup>

## Procedural skills, advanced life support and the RACGP Fellowship

Competencies in procedural skills related to emergency life support measures are critical for successful patient management. Advanced life support training is a requirement for Fellowship, and doctors must complete training in the early management of trauma and advanced life support (ALS) during vocational training (see Requirements V.12. and v.13).<sup>6</sup>

## Teaching of procedural skills

Training in technical procedures through parts of a medical practitioner's learning life has been reported as being unsystematic and unstructured.<sup>3</sup> This may be because the need for procedures which can then be used to observe, learn, and develop skill levels often arises randomly.

Doctors at all levels of their learning lives are often involved in teaching procedural skills to their juniors: the medical student may learn skills from the first year intern or the registrar from the vocational doctor, reflected in the traditional expression, 'See one, do one, teach one'. Teaching can also be an important method of reinforcing learning in the teacher. Clinicians involved in teaching need to assess their teaching processes to ensure that they are teaching technical skills in a systematic manner.

Use of simulation based teaching techniques to initially acquire and to practise skills is highly recommended.

## Related curriculum areas

Procedural skills impact on most areas of the RACGP curriculum but closely related areas include:

- *Acute and serious illness*
- *Doctor's health*
- *Pain management*
- *Practice management*
- *Quality and safety*
- *Rural health.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- PROT1.1 Understand that clearly explaining all facets of a procedure is critical to obtaining valid informed consent.
- PROT1.2 Clearly explain the reasons for the procedure; the steps of the procedure; the potential outcomes including benefits, risks and complications; and address patient interests and concerns.

## 2. Applied professional knowledge and skills

- PROT2.1 Achieve procedural skill competency level appropriate to their learning life level and workplace requirements.
- PROT2.2 Apply medical procedural knowledge relevant to the clinician's requirements by explaining indications, contraindications, patient preparation methods, sterile techniques, pain management and proper techniques for handling specimens and fluids obtained, and test results.
- PROT2.3 Recognise and manage complications of procedures including the complications of procedures that other people performed.

## 3. Population health and the context of general practice

- PROT3.1 Know the current and ongoing pattern of risks and complications of procedural errors through the reports from medical boards, alerts, bulletins, medical defence organisations, continuing education and surveillance authorities.
- PROT3.2 Use knowledge of the current and ongoing pattern of risks and complications of procedural errors to identify and minimise adverse risk associated with medical procedures.
- PROT3.3 Be aware of other procedural related risks, such as the transmission of blood borne viruses and their potential for transmission between patients and healthcare providers during procedures.

## 4. Professional and ethical role

- PROT4.1 Identify and know the level of competence required for each procedural skill level dependent upon the specific requirements for the stage of the learning life and work requirements.
- PROT4.2 Understand how the presence of psychomotor impairment or medical conditions may affect the ability to successfully and safely perform technical tasks and work practices may need to be altered to suit each particular circumstance.
- PROT4.3 Understand the requirement for limiting participation to tasks for which competence or suitability can be demonstrated in the presence of psychomotor impairment or medical conditions.
- PROT4.4 Be familiar with any professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

## 5. Organisational and legal dimensions

- PROT5.1      Ensure that procedural tasks meet the ethical and legal requirements for patient informed consent including documentation.
- PROT5.2      Understand the use of systemic processes to include a mechanism for the ongoing identification and minimisation of procedural related risks (see *Quality and safety* curriculum statement for more detail).
- PROT5.3      Ensure that practice facilities are appropriately equipped and resourced to meet procedural task requirements.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- PROLM1.1 Demonstrate the ability to counsel patients regarding the reasons for procedures.
- PROLM1.2 Demonstrate the ability to counsel patients regarding any potential outcomes including benefits, risks and complications for procedures.
- PROLM1.3 Demonstrate the ability to clearly explain the steps of procedures.
- PROLM1.4 Demonstrate how to address patient interests and concerns about procedures.
- PROLM1.5 Demonstrate communication skills necessary to obtain informed consent for procedures.

### 2. Applied professional knowledge and skills

- PROLM2.1 Demonstrate applied professional and procedural skill competence.
- PROLM2.2 Demonstrate the ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management and proper techniques for handling specimens and fluids obtained and test results for procedures.
- PROLM2.3 Describe the complications and management of procedures.

### 3. Population health and the context of general practice

- PROLM3.1 Describe patterns of potential risks and complications of procedures.
- PROLM3.2 Describe sources of information for ongoing identification of risk trends in procedural errors.
- PROLM3.3 Describe the epidemiology of hazards and risks to patients and healthcare workers associated with procedural medicine.

### 4. Professional and ethical role

- PROLM4.1 Detail procedural requirements to a level appropriate for the medical student skill setting.
- PROLM4.2 Outline processes of maintaining appropriate skill competency levels.
- PROLM4.3 Describe how psychomotor impairment or medical conditions may affect an individual's ability to successfully and safely perform technical tasks and work practices.

### 5. Organisational and legal dimensions

- PROLM5.1 Describe the ethical and legal requirements for patient informed consent for procedures.
- PROLM5.2 Describe how organisational system processes need to include a mechanism for the ongoing identification and minimisation of procedural related risks (see *Quality and safety* curriculum statement for more detail).
- PROLM5.3 Describe organisational facilities and equipment requirements necessary to provide an acceptable standard of care for procedures.
- PROLM5.4 Describe any professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- PROLP1.1 Demonstrate the ability to counsel patients regarding the reasons for procedures.
- PROLP1.2 Demonstrate the ability to counsel patients regarding any potential outcomes, including benefits, risks and complications of procedures.
- PROLP1.3 Demonstrate the ability to clearly explain the steps of procedures.
- PROLP1.4 Demonstrate how to address patient interests and concerns about procedures.

### 2. Applied professional knowledge and skills

- PROLP2.1 Demonstrate applied professional and procedural skill competence.
- PROLP2.2 Demonstrate the ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management and proper techniques for handling specimens and fluids obtained and test results for procedures.
- PROLP2.3 Describe the complications and management of procedures.

### 3. Population health and the context of general practice

- PROLP3.1 Describe patterns of potential risks and complications of procedural errors.
- PROLP3.2 Describe sources of information for ongoing identification of risk trends in procedural errors.
- PROLP3.3 Describe the epidemiology of hazards and risks to patients and healthcare workers associated with procedural medicine.

### 4. Professional and ethical role

- PROLP4.1 Detail procedural requirements to a level appropriate for the prevocational setting.
- PROLP4.2 Outline processes of maintaining appropriate skill competency levels.
- PROLP4.3 Describe how psychomotor impairment or medical conditions may affect an individual's ability to successfully and safely perform technical tasks and work practices.

### 5. Organisational and legal dimensions

- PROLP5.1 Describe the ethical and legal requirements for patient informed consent for procedures.
- PROLP5.2 Describe how organisational system processes need to include a mechanism for the ongoing identification and minimisation of procedural related risks (see *Quality and safety* curriculum statement for more detail).
- PROLP5.3 Describe organisational facilities and equipment requirements necessary to provide an acceptable standard of care for procedures. Describe any professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge — prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- PROLV1.1 Demonstrate the ability to counsel patients regarding the reasons for procedures.
- PROLV1.2 Demonstrate the ability to counsel patients regarding any potential outcomes including benefits, risks and complications for procedures.
- PROLV1.3 Demonstrate the ability to clearly explain the steps of procedures.
- PROLV1.4 Demonstrate how to address patient interests and concerns about procedures.

### 2. Applied professional knowledge and skills

- PROLV2.1 Demonstrate applied professional and procedural skill competence.
- PROLV2.2 Demonstrate ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management and proper techniques for handling specimens and fluids obtained and test results for procedures.
- PROLV2.3 Describe the complications and management of procedures.

### 3. Population health and the context of general practice

- PROLV3.1 Describe patterns of potential risks and complications of procedural errors.
- PROLV3.2 Describe sources of information for ongoing identification of risk trends in procedural errors.
- PROLV3.3 Describe the epidemiology of hazards and risks to patients and healthcare workers associated with procedural medicine.

### 4. Professional and ethical role

- PROLV4.1 Detail procedural requirements to a level consistent with the requirements for Fellowship of The Royal Australian College of General Practitioners.
- PROLV4.2 Describe processes of maintaining appropriate skill competency levels. This includes adjusting for changing career skill level requirements over the course of continuing professional development.
- PROLV4.3 Describe how psychomotor impairment or medical conditions may affect an individual's ability to successfully and safely perform technical tasks and work practices.

### 5. Organisational and legal dimensions

- PROLV5.1 Describe the ethical and legal requirements for patient informed consent for procedures.
- PROLV5.2 Describe how organisational system processes need to include a mechanism for the ongoing identification and minimisation of procedural related risks (see *Quality and safety* curriculum statement for more detail).
- PROLV5.3 Describe organisational facilities and equipment requirements necessary to provide an acceptable standard of care for procedures. Describe any professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge — vocational doctor

### 1. Communication skills and the patient-doctor relationship

- PROLC1.1 Demonstrate the ability to counsel patients regarding the reasons for procedures.
- PROLC1.2 Demonstrate the ability to counsel patients regarding any potential outcomes, including benefits, risks and complications for procedures.
- PROLC1.3 Demonstrate the ability to clearly explain the steps of procedures.
- PROLC1.4 Demonstrate how to address patient interests and concerns about procedures.

### 2. Applied professional knowledge and skills

- PROLC2.1 Demonstrate maintenance of applied professional and procedural skill competence levels.
- PROLC2.2 Demonstrate ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management and proper techniques for handling specimens and fluids obtained and test results for procedures.
- PROLC2.3 Describe the complications and management of procedures.

### 3. Population health and the context of general practice

- PROLC3.1 Describe patterns of potential risks and complications of procedural errors.
- PROLC3.2 Describe sources of information for ongoing identification of risk trends in procedural errors.
- PROLC3.3 Describe the epidemiology of hazards and risks to patients and healthcare workers associated with procedural medicine.

### 4. Professional and ethical role

- PROLC4.1 Detail procedural requirements appropriate to the clinician's specific clinical setting, for example primary healthcare, obstetrics, and others.
- PROLC4.2 Discuss processes of maintaining appropriate skill competency levels. This includes adjusting for changing career skill level requirements over the course of continuing professional development.
- PROLC4.3 Describe how psychomotor impairment or medical conditions may affect an individual's ability to successfully and safely perform technical tasks and work practices.

### 5. Organisational and legal dimensions

- PROLC5.1 Describe the ethical and legal requirements for patient informed consent for procedures to the appropriate level of applied professional knowledge and skills.
- PROLC5.2 Demonstrate organisational systems for the ongoing identification and minimisation of procedural related risks (see *Patient safety* curriculum statement for more detail).
- PROLC5.3 Indicate organisational measures, facilities and equipment in place to provide an acceptable standard of care for procedures. Describe any professional, legal and jurisdictional requirements regarding eligibility to perform particular procedures.

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## *Quality use of medicines*

### Contents

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Definition	529
Rationale and general practice context	530
Training outcomes of the five domains of general practice	534
Learning objectives across the GP professional life	537
<i>Medical student</i>	537
<i>Prevocational doctor</i>	539
<i>Vocational registrar</i>	542
<i>Continuing professional development</i>	545
References	547

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## Definition

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The quality use of medicines refers to the process of:

- selecting patient management options wisely
- choosing suitable medicines if a medicine is considered necessary
- using medicines safely and effectively.<sup>1</sup>

The term 'medicine' includes prescription, nonprescription and complementary medicines.<sup>2</sup>

This definition of quality use of medicine not only applies to medicines in the general practice setting, but also to all medicines used by individual patients that can affect their health. This whole-health system view is necessary as general practice patients obtain their medications from a range of sources such as those initiated by themselves, other general practitioners, other medical specialists, pharmacists and complementary therapists.

Quality use of medicines is one of the central objectives of Australia's National Medicines Policy and is a key criterion in the RACGP *Standards for general practices*.<sup>3</sup>

## Curriculum in practice

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The following case illustrates how the quality use of medicines curriculum applies to general practice:

- Roger, 39 years of age, is a builder who attends the practice irregularly, usually if he needs antibiotics for infected wounds such as his presentation today. You notice that he hasn't had a blood pressure check for several years and find it is 150/95 mmHg. He is otherwise well, does not smoke, drinks about 3–4 beers after work with his work mates, and is up-to-date with his vaccinations. Roger's family history is unremarkable; both his parents are alive and well, although his father is on medication for hypertension and high cholesterol. You recheck Roger's blood pressure on subsequent occasions, which remains elevated. All other investigations show no abnormalities. You discuss commencing antihypertensive medications with Roger, but he says that he is a well man and can't see why he should start lifelong medication when he has no symptoms. He starts work early in the morning and often works in high places where postural dizziness would be dangerous. Does he really need medication? If so, what medication would be best? How would you monitor his response?

## Rationale and general practice context

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Every year there are more than 115 million general practice encounters in Australia<sup>4</sup> and over 200 million prescriptions dispensed by pharmacies each year.<sup>5</sup> This represents the equivalent of more than eight prescriptions per Australian per year.<sup>5</sup> Medications are recommended or prescribed in 43% of Australian general practice consultations.<sup>4</sup> There are also many over-the-counter medications resulting in nearly 70% of all Australians (and nearly 90% of older Australians), taking at least one medication per fortnight. Over 1.5 million Australians suffer an adverse event from medicines each year. This results in at least 400 000 visits to general practitioners and 140 000 hospital admissions.<sup>6</sup>

General practitioners need the required skills for the quality use of medicines in the practice setting, which include<sup>1,7</sup>:

- selecting management options wisely by:
  - considering the place of medicines in treating illness and maintaining health
  - recognising that there may be better ways than medicine to manage many disorders
- choosing suitable medicines, if a medicine is necessary, so that the best available option is selected by taking into account:
  - the individual and their understanding and expectations of medicines
  - their clinical condition
  - their risks and benefits
  - dosage and length of treatment
  - any co-existing conditions – such as other medical conditions – and individual factors such as age, pregnancy, impaired liver, kidney or heart function
  - other therapies especially polypharmacy
  - monitoring considerations
  - costs for the individual, the community and the health system.

Rational prescribing skills are necessary for choosing the most suitable available medicine and include<sup>7</sup>:

- prescribing within the limitations of the treating doctor's knowledge, skills and experience
- being clear about the reasons for prescribing and communicating these to the patient including the potential benefits and risks
- using medicines only when appropriate, with nonmedicinal alternatives considered as needed. This includes medicines which are prescribed, recommended and/or self selected
- using efficacious medications that aim to achieve the goals of therapy by delivering beneficial changes in actual health outcomes in accordance with accepted prescribing national guidelines where appropriate
- choosing the most appropriate medicine, taking into account factors such as the clinical condition being treated, the potential benefits and risks of treatment, dosage, length of treatment and cost
- taking into account the patient's ideas, concerns and expectations
- safety considerations (see 'using medicines safely and effectively').

General practitioners must have the knowledge and skills to use medicines to their best effect and must also have access to current and accurate information, electronic supports and education. This includes resources such as the *Australian Medicines Handbook*, *Therapeutic Guidelines*, *Australian Prescriber*, adverse drug reports and bulletins and the National Prescribing Service.

General practitioners also have an ethical and professional obligation to manage the potential risk of other influences on the prescribing relationship such as from industry sources, advertising and the media.<sup>8</sup>

## Using medicines safely and effectively

Using medicines safely and effectively in general practice is achieved by:

- writing or printing unambiguous legal prescriptions using the correct documentation
- monitoring outcomes including benefits and adverse events
- minimising misuse, over-use and under-use
- improving a patient's ability to solve problems related to medication, such as negative effects or managing multiple medications.

Medication error in the community is a complex issue with no single factor being responsible. Minimising the risk of medications errors involves doctors, patients, the practice and broader system based approaches to promote patient safety. Quality use of medication education needs to address these broad aspects of medication safety.

Medication errors are estimated to affect around 10% of general practice patients and up to 25% of high risk patients who report medicine adverse events.<sup>9</sup> The groups at highest risk are the elderly, those taking multiple medications and those taking high risk medications. Cardiovascular drugs, antithrombotic agents, analgesics, antibiotics, oral antidiabetic agents, antidepressants, anti-epileptic drugs and chemotherapeutic agents are the medications associated with the highest risk of adverse events in the adult population.

In the paediatric population, respiratory drugs, antibiotics, antihistamines and analgesics are most commonly associated with adverse events.

## Antimicrobial resistance

The rise of community acquired antibiotic resistance requires judicious prescribing on the part of GPs to slow down the emergence of antibiotic resistance.<sup>10</sup> Key principles that GPs need to include:

- being aware of best practice antibiotic prescribing for each disease through the use of current guidelines
- evaluating antibiotic use within the practice (eg. through clinical audits)
- applying consistent prescribing practices
- educating patients about the best and appropriate use of antibiotics.<sup>10</sup>

Issues of antimicrobial resistance go beyond antibiotics and can also be a problem for some viral,<sup>11,12</sup> fungal and parasitic diseases.<sup>13</sup>

## Managing adverse medication events

General practitioners need to know how to manage medication adverse events including within the practice setting, and reporting adverse medicine reactions to the appropriate authorities.

## The role of communication in quality use of medicines

As in all areas of general practice, effective and open communication with patients, members of the general practice team and the broader health sector are critical for achieving quality use of medicines.

General practitioners need to clearly communicate why a medicine is, or is not, required and provide clear advice when recommending medicines to help minimise risks and maximise medicine safety. This includes addressing the patient's understanding of their management and identifying any barriers to effective communication such as cultural and linguistic diversity, disability and health literacy problems. This enables the doctor and the patient to arrive at a satisfactory mutually negotiated management outcome.

Open communication is also required to identify other medications that the patient may be taking that were not initiated by the GP, including over-the-counter medications and complementary therapies.

For example, almost two-thirds of the community have used some form of complementary medicine and many do not disclose this to their doctor. Research shows that more than half of people taking complementary medicines do not tell their doctor and about 50% used conventional medicines on the same day.<sup>14</sup> This is a potentially unsafe use of medicine.<sup>15,16</sup> For more information see the curriculum statement *Integrative medicine*.

As highlighted in the *Quality and Safety* curriculum statement, communication errors are reported to be the leading causes of patient harm and this applies to quality use of medicines. Poor communication is the most commonly reported contributing factor in medication errors between patients and health professionals, GPs and pharmacists and health professionals at the transfer-of-care.

Poor communication after an adverse event can determine the decision to take legal action.<sup>17</sup> Medication errors involving GPs currently account for about 8% of medical negligence claims.<sup>18</sup>

Errors have been shown to occur during all stages of the medication process including prescribing, supply, administration, monitoring and documentation. However, the highest risk of error is during transfer of care, with Australian and overseas studies finding that 52% to 88% of transfer documents contain an error.<sup>9</sup> Rates of prescribing errors were found to be as high as 32 errors per 100 prescriptions in overseas studies and up to 115 errors per 100 high risk patients in Australian studies.<sup>9</sup>

A prescription is essentially a type of handover document that needs to be unambiguously and legally written or printed using the correct documentation. Good patient handover skills are important to promote quality use of medicines for GPs and are covered in the *Quality and safety* curriculum statement.

General practices need to be able to use communication tools such as briefings, clear handover procedures, good record keeping, electronic prescribing tools, patient information materials and checklists to improve quality use of medicines and reduce the rate of patient harm.<sup>19</sup>

Systems to minimise medication errors therefore have the potential to significantly reduce patient harm in the general practice setting.

## Health promotion and quality use of medicines

General practitioners can promote the quality use of medicines in the community through good treatment choices with patients. For example, this could be taking the time to explain that antibiotics are unnecessary in an upper respiratory tract infection, or the use of lifestyle measures instead of medication.

## Multidisciplinary care and quality use of medicines.

Communication also needs to be clear with members of the practice team and the broader health sector to ensure continuity of patient care, especially regarding ensuring that any changes to medicines are carefully documented and communicated.

## Practice based systems and quality improvement

Teamwork and practice systems are critical aspect of quality use of medicines. Accurate record keeping to ensure that all health providers are aware of a patient's current medicine use and ensuring that patient safety information is detected, recorded and shared such as allergies and drug reactions.

Practice based systems are also becoming increasingly important as an aspect of quality improvement, using tools such as clinical audits to help improve patient outcomes. These tools have been demonstrated to be effective in improving care including the quality use of medicines. For more information see curriculum statement *Quality and safety*.

## Cost effective prescribing

While the first and overriding consideration of prescribing medications is evidence based, a responsible prescriber will also consider cost effectiveness. While there are a range of schemes to subsidise the cost of medication for an individual, noncompliance due to affordability remains an additional source of concern for quality use of medications.

Although subsidies exist to improve medication affordability, 13.4% of Australians report not having a prescription filled due to cost in the preceding 12 months.<sup>20</sup> This indicates the impact that cost has on treatment adherence and patient safety.

In the context of an aging population, cost effective prescribing is also a consideration in minimising the subsidised medication costs to the Australian community.

### Related curriculum areas

Quality use of medicine impacts on all curriculum areas, but in particular the following:

- *E-health*
- *Integrative medicine*
- *Multidisciplinary care*
- *Practice management*
- *Quality and safety.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- QUMT1.1      Communicate clearly with patients and carers the reasons for prescribing or not prescribing, including the potential benefits and risks.
- QUMT1.2      Take into account the patient's ideas, concerns and expectations when negotiating medicine use, including patient cultural and personal preferences for the nature of treatment with both conventional and complementary therapies.
- QUMT1.3      Provide clear advice about medicine administration when recommending medicines.
- QUMT1.4      Create a nonjudgmental and open environment for patient-doctor communication so that patients can discuss any concerns regarding their medicine use. Also promote the identification of other medicines that the patient may be taking that were not initiated by the GP, including over-the-counter medicines and complementary therapies.
- QUMT1.5      Assess the influence of health literacy of patient and carer on their understanding of their use of medicines and incorporate this into patient-doctor communications.
- QUMT1.6      Use communication methods, tools and patient resources to promote quality use of medicines including treatment adherence.

## 2. Applied professional knowledge and skills

- QUMT2.1      Use medicines only when appropriate and consider nonmedicinal alternatives as needed.
- QUMT2.2      Understand the principles of quality use of medicines to the general practice setting.
- QUMT2.3      Prescribe within the limitations of the treating doctor's knowledge, skills and experience.
- QUMT2.4      Select the most appropriate medicine and take into account factors such as the clinical condition being treated, the potential benefits and risks of treatment, dosage and length of treatment and cost.
- QUMT2.5      Know the interactions of drug-disease, drug-patient and drug-drug relationships for likely clinical presentations, ranging from acute self limiting conditions to chronic complex diseases. Understand the natural course of the disease.
- QUMT2.6      When choosing medicines, select the best available option and include the following factors in this choice:
- the individual person and their understanding and expectations of medicines
  - the clinical condition
  - risks and benefits of the medicine
  - dosage and length of treatment
  - any co-existing conditions such as other medical conditions and multiple pathologies. Also consider individual factors such as age, pregnancy, impaired liver, kidney or heart function
  - other therapies especially polypharmacy
  - monitoring considerations
  - costs to the individual, the community and the health system
  - safety considerations.

- QUMT2.7 Write or print unambiguous legal prescriptions using the correct documentation.
- QUMT2.8 Accurately list patient medications and instructions.
- QUMT2.9 Apply current, timely prescribing guidelines and resources to the quality use of medicines in the general practice setting.
- QUMT2.10 Assess the significance of potential and actual multidimensional drug interactions for minimising patient harm including the management of polypharmacy.
- QUMT2.11 Manage adverse medicine events within the practice, and in the event of a medication reaction, report events to the appropriate monitoring organisations as appropriate.
- QUMT2.12 Monitor treatment outcomes including benefits and adverse events.
- QUMT2.13 Be able to use electronic prescribing software appropriately.

### 3. Population health and the context of general practice

- QUMT3.1 Promote the quality use of medicines in patients and the community through good treatment choices with patients.
- QUMT3.2 Understand the National Medicines Policy and the place of quality use of medicines.
- QUMT3.3 Understand the common patterns of medicine use in the community including prescribed, over-the-counter and self selected medicines.
- QUMT3.4 Apply the quality use of medicine to antimicrobial use in the general practice setting including consistent prescribing practices; using current microbial prescribing guidelines; evaluating antibiotic use within the practice; and educating patients about the best and appropriate use of antibiotics.
- QUMT3.5 Understand the influence of culture and language on the quality use of medicines.
- QUMT3.6 Understand the impact of cost on quality use of medicines on the individual, families and the broader health system.

### 4. Professional and ethical role

- QUMT4.1 Recognise personal limitations of the knowledge, skills and experience when prescribing and know where to seek further assistance.
- QUMT4.2 Work effectively within a multidisciplinary setting to help reduce medication errors, especially within the context of clinical handover.
- QUMT4.3 Understand professional obligations to report adverse medicine events to appropriate organisations.
- QUMT4.4 Understand professional requirements for quality use of medicine as documented in the RACGP *Standards for general practices*.
- QUMT4.5 Understand the potential for nontherapeutic influences on prescribing choices such as industry sources, advertising and the media.
- QUMT4.6 Disclose any potential conflicts of interest (eg. if research is being conducted in the general practice setting).

## 5. Organisational and legal dimensions

- QUMT5.1      Communicate clearly with members of the practice team, other multidisciplinary care teams and the broader health sector to ensure continuity of patient care, ensuring that any changes to medicines are appropriately documented and communicated.
- QUMT5.2      Ensure that all prescriptions are written or printed unambiguously and meet legal requirements and use the correct documentation.
- QUMT5.3      Keep accurate patient records to ensure that all health providers are aware of a patient's current medicine use and ensure that patient safety information is detected, recorded and shared (such as allergies and drug reactions).
- QUMT5.4      Be able to access current information on medicines.
- QUMT5.5      Understand the availability of various government subsidy schemes to assist patients, such as PBS co-payment schemes and supports for Aboriginal and Torres Strait Islander people.
- QUMT5.6      Understand the precise requirements, limitations and processes relating to prescribing, including those for the Pharmaceutical Benefits Scheme (such as Restricted or Authority medications) and the jurisdictional requirements for S4 and S8 medicines.
- QUMT5.7      Understand the appropriate storage of medicines within the practice including in doctors bags.
- QUMT5.8      Use teamwork and practice systems to improve the quality use of medicines by reviewing prescribing patterns in accordance with best available evidence such as clinical audits.
- QUMT5.9      Know how to document medicine adverse events, or near misses, and how to implement change based on these events in accordance with clinical governance principles detailed in the RACGP *Standards for general practices*.
- QUMT5.10     Understand the use of practice systems including briefings, clear handover procedures, good record keeping including electronic prescribing tools, patient information materials and checklists to improve quality use of medicines.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- QUMLM1.1 Outline communication issues with patients and carers that promote the quality use of medicines.
- QUMLM1.2 Describe how a patient's ideas, concerns and expectations, including cultural and personal preferences for the nature of treatment with both conventional and complementary therapies, may influence medicines choice.
- QUMLM1.3 Demonstrate skills for providing clear advice about medicine administration.
- QUMLM1.4 Describe the influence of a nonjudgmental and open environment for patient-doctor communication for patients to be able to discuss any concerns regarding their medicine use.
- QUMLM1.5 Investigate communication methods, tools and patient resources to promote quality use of medicines including treatment adherence in various health settings.

### 2. Applied professional knowledge and skills

- QUMLM2.1 Discuss conditions where nonmedicinal alternatives might be considered in place of medicines.
- QUMLM2.2 Describe the general principles of quality use of medicines.
- QUMLM2.3 Outline the effect of the limitations of a treating doctor's knowledge, skills and experience on prescribing.
- QUMLM2.4 Discuss the general factors that influence prescribing such as the clinical condition being treated, the potential benefits and risks of treatment, dosage, length of treatment and cost.
- QUMLM2.5 Outline the patterns of potential and actual interactions between medicines, the patient and their diseases.
- QUMLM2.6 Discuss how the following factors can affect medicine choices:
- the individual person and their understanding and expectations of medicines
  - the clinical condition
  - risks and benefits and the medicine
  - dosage and length of treatment
  - any co-existing conditions such as other medical conditions, multiple pathologies and individual factors like age, pregnancy, impaired liver, kidney or heart function
  - other therapies especially polypharmacy
  - monitoring considerations
  - costs for the individual, the community and the health system
  - safety considerations.
- QUMLM2.7 Outline the requirements for writing/printing unambiguous legal prescriptions using the correct documentation including the use of electronic prescribing software.
- QUMLM2.8 Outline the importance of accurately listing and documenting patient medications and instructions.

- QUMLM2.9 Outline the role of current, timely prescribing guidelines and resources in the quality use of medicines.
- QUMLM2.10 Discuss the general principles of potential and actual drug interactions including polypharmacy.
- QUMLM2.11 Outline the principles of monitoring treatment outcomes.
- QUMLM2.12 Outline the key features of adverse medicine events and their reporting requirements.

### 3. Population health and the context of general practice

- QUMLM3.1 Outline the promotion of quality use of medicines in patients.
- QUMLM3.2 Outline the National Medicines Policy and the public health aspects of quality use of medicines.
- QUMLM3.3 Outline the types and patterns of medicine use including prescribed, over-the-counter and self selected medicines.
- QUMLM3.4 Discuss the quality use of medicines to antimicrobial use in the hospital and community settings. Also outline the impact of consistent prescribing practices using current microbial prescribing guidelines, ongoing evaluation of antibiotic use and patient education about the best and appropriate use of antibiotics.
- QUMLM3.5 Discuss the influence of culture and language on the quality use of medicines in the hospital setting.

### 4. Professional and ethical role

- QUMLM4.1 Discuss how personal limitations of knowledge, skills and experience have the potential to affect prescribing and outline management when quality use of medicine issues are outside these limitations.
- QUMLM4.2 Discuss how multidisciplinary care may help reduce medication errors especially within the context of a clinical handovers.
- QUMLM4.3 Describe systems for reporting adverse medicine events.
- QUMLM4.4 Discuss how non therapeutic factors could affect prescribing choices such as industry sources, advertising and the media.
- QUMLM4.5 Outline the importance of disclosing any potential conflicts of interest (eg. between treatment and research).

### 5. Organisational and legal dimensions

- QUMLM5.1 Outline the importance of communication with co-workers, multidisciplinary care teams and the broader health sector to ensure continuity of patient care, ensuring that any changes to medicines are appropriately documented and managed.
- QUMLM5.2 Outline the legal requirements of prescriptions.
- QUMLM5.3 Discuss the importance of accurate patient records to ensure that all health providers are aware of a patient's current medicine use and ensuring that patient safety information is detected, recorded and shared (such as allergies and drug reactions).
- QUMLM5.4 Outline how to access current information on medicines.
- QUMLM5.5 Discuss the requirements, limitations and processes relating to prescribing including those for the Pharmaceutical Benefits Scheme (such as Restricted or Authority medications) and the jurisdictional requirements for S4 and S8 medicines in the general practice setting.
- QUMLM5.6 Outline how teamwork and system approaches can be used to improve the quality use of medicines.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- QUMLP1.1 Demonstrate the ability to communicate the reasons for prescribing (including the potential benefits and risks in the hospital setting) to patients and carers.
- QUMLP1.2 Consider the patient's ideas, concerns and expectations when negotiating medicine use (including patient cultural and personal preferences for the nature of treatment with both conventional and complementary therapies in the hospital setting).
- QUMLP1.3 Demonstrate how to provide clear advice about medicine administration when recommending medicines in the hospital setting.
- QUMLP1.4 Outline how to create a nonjudgmental and open environment for patient-doctor communication for patients to discuss any concerns regarding their medicine use. Also promote the identification of other medicines that the patient may be taking not initiated by the treating doctor.
- QUMLP1.5 Describe communication methods, tools and patient resources to promote quality use of medicines (including treatment adherence in the hospital setting).

### 2. Applied professional knowledge and skills

- QUMLP2.1 Describe conditions where nonmedicinal alternatives could be considered in place of medicines.
- QUMLP2.2 Describe the principles of quality use of medicines in the hospital setting.
- QUMLP2.3 Describe how to prescribe within the limitations of the treating doctor's knowledge, skills and experience in the hospital setting.
- QUMLP2.4 Describe the potential benefits and risks of treatment. Also describe the medication dosages, length of treatment, and the cost effective choices of particular medications when prescribing.
- QUMLP2.5 Describe the potential drug-disease, drug-patient and drug-drug interactions for clinical presentations in the hospital setting.
- QUMLP2.6 Describe how the following factors can affect medicine choice in the hospital setting:
  - the individual person and their understanding and expectations of medicines
  - the clinical condition
  - risks and benefits and the medicine
  - dosage and length of treatment
  - any co-existing conditions, eg. other medical conditions, multiple pathologies and individual factors such as age, pregnancy, impaired liver, kidney or heart function
  - other therapies especially polypharmacy
  - monitoring considerations
  - costs for the individual, the community and the health system
  - safety considerations.

- QUMLP2.7 Demonstrate how to write and print unambiguous legal prescriptions using the correct documentation in the general practice setting.
- QUMLP2.8 Demonstrate how to accurately list patient medications and instructions in the general practice setting.
- QUMLP2.9 Describe how to apply current, timely prescribing guidelines and resources to the quality use of medicines in the hospital setting.
- QUMLP2.10 Outline and discuss the potential and actual drug interactions, including the management of polypharmacy in the hospital setting.
- QUMLP2.11 Describe the principles of monitoring treatment outcomes including benefits and adverse events.
- QUMLP2.12 Describe the management of adverse medicine events within the hospital setting, including event reporting requirements.
- QUMLP2.13 Outline the use of electronic prescribing software.

### 3. Population health and the context of general practice

- QUMLP3.1 Describe how to promote the quality use of medicines in patients.
- QUMLP3.2 Outline the National Medicines Policy and the place of quality use of medicines in the hospital setting.
- QUMLP3.3 Outline the common patterns of medicine use including prescribed, over-the-counter and self selected medicines.
- QUMLP3.4 Demonstrate the application of the quality use of medicine to antimicrobial use in the hospital setting including consistent prescribing practices, using current microbial prescribing guidelines and educating patients about the best and appropriate use of antibiotics.
- QUMLP3.5 Describe the influence of culture and language on the quality use of medicines in the hospital setting.

### 4. Professional and ethical role

- QUMLP4.1 Outline how personal limitations of knowledge, skills and experience have the potential to affect prescribing and outline where to seek further assistance.
- QUMLP4.2 Describe how to work effectively within a multidisciplinary setting to help reduce medication errors especially within the context of a clinical handover to and from the hospital setting.
- QUMLP4.3 Outline professional obligations for reporting adverse medicine events within the hospital setting.
- QUMLP4.4 Identify potential nontherapeutic influences on prescribing choices such as industry sources, advertising and the media.
- QUMLP4.5 Outline the importance of disclosing any potential conflicts of interest (eg. if research is being conducted in the current workplace setting).

## 5. Organisational and legal dimensions

- QUMLP5.1 Demonstrate clear communication with members of the practice team, other multidisciplinary care teams and the broader health sector to ensure continuity of patient care ensuring that any changes to medicines are appropriately documented and managed.
- QUMLP5.2 Describe the legal requirements of prescriptions in the general practice setting.
- QUMLP5.3 Demonstrate the ability to keep accurate patient records to ensure that all health providers are aware of a patient's current medicine use and that patient safety information is detected, recorded and shared such as allergies and drug reactions.
- QUMLP5.4 Describe how to access current information on medicines.
- QUMLP5.5 Detail the requirements, limitations and processes relating to prescribing including those for the Pharmaceutical Benefits Scheme (such as Restricted or Authority medications) and the jurisdictional requirements for S4 and S8 medicines in the general practice setting.
- QUMLP5.6 Outline how teamwork and practice systems can be used to improve the quality use of medicines in the hospital setting.
- QUMLP5.7 Describe the use of hospital systems including briefings, clear handover procedures, good record keeping including electronic prescribing tools, patient information materials and checklists to improve quality use of medicines.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- QUMLV1.1 Demonstrate the ability to communicate clearly with patients and carers the reasons for prescribing, including the potential benefits and risks in the general practice setting.
- QUMLV1.2 Demonstrate how to take into account the patient's ideas, concerns and expectations when negotiating medicine use (including patient cultural and personal preferences for the nature of treatment with both conventional and complementary therapies).
- QUMLV1.3 Demonstrate how to provide clear advice about medicine administration when recommending medicines.
- QUMLV1.4 Describe how to create a nonjudgmental and open environment for patient-doctor communication in order for patients to be able to discuss any concerns regarding their medicine use. Also promote the identification of other medicines the patient may be taking that were not initiated by the GP (including over-the-counter medicines and complementary therapies).
- QUMLV1.5 Outline the assessment of the patient and carer understanding of their use of medicines and incorporate this into patient-doctor communications.
- QUMLV1.6 Describe communication methods, tools and patient resources to promote quality use of medicines including treatment adherence.

### 2. Applied professional knowledge and skills

- QUMLV2.1 Outline how to use medicines appropriately and consider nonmedicinal alternatives, including medicines that are prescribed, recommended and/or self selected.
- QUMLV2.2 List the principles of quality use of medicines in the general practice setting.
- QUMLV2.3 Describe how to prescribe within the limitations of the treating doctor's knowledge, skills and experience within the general practice setting.
- QUMLV2.4 Describe how the clinical condition, the potential benefits and risks of treatment, dosage, length of treatment and cost affect medicine choice when prescribing.
- QUMLV2.5 Describe the potential drug-disease, drug-patient and drug-drug interactions for clinical presentations ranging from acute self limiting conditions to chronic complex diseases and incorporate an understanding of the natural course of the disease.
- QUMLV2.6 Describe how the following factors can affect medicine choice in the general practice setting:
- the individual person and their understanding and expectations of medicines
  - the clinical condition
  - risks and benefits and the medicine
  - dosage and length of treatment
  - any co-existing conditions, eg. other medical conditions, multiple pathologies and individual factors such as age, pregnancy, impaired liver, kidney or heart function.
  - other therapies especially polypharmacy
  - monitoring considerations

- costs for the individual, the community and the health system
  - safety considerations.
- QUMLV2.7 Demonstrate how to write and print unambiguous legal prescriptions using correct documentation in the general practice setting.
- QUMLV2.8 Demonstrate how to accurately list patient medications and instructions in the general practice setting.
- QUMLV2.9 Describe how to apply current, timely prescribing guidelines and resources to the quality use of medicines in the general practice setting.
- QUMLV2.10 Outline and discuss the significance of potential and actual multidimensional drug interactions for minimising patient harm, including the management of polypharmacy in the general practice setting.
- QUMLV2.11 Describe the management of adverse medicine events within the practice, and in the event of adverse medication reactions, reporting events to the appropriate monitoring bodies.
- QUMLV2.12 Describe the principles of monitoring treatment outcomes including benefits and adverse events.
- QUMLV2.13 Demonstrate the use of electronic prescribing software appropriately.

### 3. Population health and the context of general practice

- QUMLV3.1 Describe how to promote the quality use of medicines in patients and the community through good treatment choices with patients.
- QUMLV3.2 Outline the National Medicines Policy and the place of quality use of medicines in general practice.
- QUMLV3.3 Discuss the common patterns of medicine use in the community including prescribed, over-the-counter and self selected medicines.
- QUMLV3.4 Demonstrate the application of the quality use of medicine to antimicrobial use in the general practice setting. Include consistent prescribing practices using current microbial prescribing guidelines, evaluating antibiotic use within the practice and educating patients about the best and appropriate use of antibiotics.
- QUMLV3.5 Outline the influence of culture and language on the quality use of medicines in the general practice setting.
- QUMLV3.6 Describe the impact of cost on quality use of medicines on the individual, families and the broader health system.

### 4. Professional and ethical role

- QUMLV4.1 Reflect on personal limitations of the knowledge, skills and experience when prescribing and outline where to seek further assistance.
- QUMLV4.2 Describe how to work effectively within a multidisciplinary setting to help reduce medication errors, especially within the context of a clinical handover to and from the general practice.
- QUMLV4.3 Outline professional obligations for reporting adverse medicine events to appropriate organisations.
- QUMLV4.4 Outline professional requirements for quality use of medicine as documented in the *RACGP Standards for general practices*.
- QUMLV4.5 Discuss the potential for nontherapeutic influences on prescribing choices such as industry sources, advertising and the media.
- QUMLV4.6 Describe how to disclose any potential conflicts of interest (eg. if research is being conducted in the general practice setting).

## 5. Organisational and legal dimensions

- QUMLV5.1 Demonstrate clear communication with members of the practice team, other multidisciplinary care teams and the broader health sector to ensure continuity of patient care ensuring that any changes to medicines are appropriately documented and managed.
- QUMLV5.2 Describe the legal requirements of prescriptions.
- QUMLV5.3 Demonstrate the ability to keep accurate patient records to ensure that all health providers are aware of a patient's current medicine use and ensuring that patient safety information is detected, recorded and shared such as allergies and drug reactions.
- QUMLV5.4 Describe how to access current information on medicines.
- QUMLV5.5 Outline various government subsidy schemes to assist patients such as PBS co-payment schemes and supports for Aboriginal and Torres Strait Islander people.
- QUMLV5.6 Detail the requirements, limitations and processes relating to prescribing including those for the Pharmaceutical Benefits Scheme (such as Restricted or Authority medications) and the jurisdictional requirements for S4 and S8 medicines.
- QUMLV5.7 Outline the appropriate storage of medicines within the practice including in the doctor's bags.
- QUMLV5.8 Outline how teamwork and practice systems could be used to improve the quality use of medicines, including clinical audits and the quality use of medicines such as antibiotic use.
- QUMLV5.9 Outline how to document medicine adverse events or near misses and how to implement change based on these events in accordance with clinical governance principles detailed in the RACGP *Standards for general practices*.
- QUMLV5.10 Describe the use of practice systems including briefings, clear handover procedures, good record keeping including electronic prescribing tools, patient information materials and checklists to improve quality use of medicines.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- QUMLC1.1 Discuss and explore the role of communication in medicine adherence.
- QUMLC1.2 Demonstrate the creation of a nonjudgmental and open environment for patient-doctor communication so patients can discuss any concerns regarding their medicine use. Also promote the identification of other medicines a patient may be taking that were not initiated by a GP, including over-the-counter medicines and complementary therapies.
- QUMLC1.3 Demonstrate continual assessment and communication of the patient and carer understanding of their use of medicines.

### 2. Applied professional knowledge and skills

- QUMLC2.1 Be able to use quality improvement processes for promoting the quality use of medicines including using clinical audits.
- QUMLC2.2 Maintain knowledge of current, timely prescribing guidelines and resources for the quality use of medicines in the general practice setting.
- QUMLC2.3 Demonstrate approaches to minimise harm from potential and actual drug interactions, including the management of polypharmacy in the general practice setting.
- QUMLC2.4 Demonstrate the management of adverse medicine events within the practice, and in the event of adverse medication reaction, reporting events to the appropriate monitoring bodies.
- QUMLC2.5 Demonstrate the monitoring of treatment outcomes.

### 3. Population health and the context of general practice

- QUMLC3.1 Demonstrate the promotion of the quality use of medicines in patients and the community through good treatment choices with patients.
- QUMLC3.2 Discuss the common patterns of medicine use in the practice population.
- QUMLC3.3 Demonstrate that the quality use of medicines in relation to antimicrobial use in the general practice setting.
- QUMLC3.4 Describe the impact of cost on quality use of medicines on the individual, families and the broader health system.

## 4. Professional and ethical role

- QUMLC4.1 Initiate continual professional development after identifying personal limitations of prescribing knowledge, skills and experience when prescribing.
- QUMLC4.2 Demonstrate the ability to work effectively within a multidisciplinary setting to help reduce medication errors, especially within the context of clinical handovers.
- QUMLC4.3 Demonstrate meeting professional requirements for quality use of medicine as documented in the RACGP *Standards for general practices*.

## 5. Organisational and legal dimensions

- QUMLC5.1 Discuss practice processes for clear communication with members of the practice team, other multidisciplinary care teams and the broader health sector.
- QUMLC5.2 Outline the practice processes for accurate patient records to ensure that all health providers are aware of a patient's current medicine use. Also ensure that patient safety information is detected, recorded and shared (such as allergies and drug reactions).
- QUMLC5.3 Demonstrate the practice's access to current information on medicines.
- QUMLC5.4 Demonstrate appropriate documentation and compliance with prescribing in accordance with the Pharmaceutical Benefits Scheme (such as Restricted or Authority medications) and the jurisdictional requirements for S4 and S8 medicines.
- QUMLC5.5 Demonstrate the appropriate storage of medicines within the practice including in the doctor's bags.
- QUMLC5.6 Demonstrate quality improvement practice processes for the quality use of medicines including clinical audits, where appropriate.
- QUMLC5.7 Demonstrate the documentation of adverse medicine events or near misses and the implementation of change based on these events in accordance with clinical governance principles detailed in the RACGP *Standards for general practices*.
- QUMLC5.8 Demonstrate the use of practice systems including briefings, clear handover procedures, good record keeping including electronic prescribing tools, patient information materials and checklists to improve quality use of medicines.

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## *Teaching, mentoring and leadership in general practice*

### Contents

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Definition	551
Curriculum in practice	551
Rationale and general practice context	552
Training outcomes of the five domains of general practice	555
Learning objectives across the GP professional life	557
<i>Medical student</i>	557
<i>Prevocational doctor</i>	559
<i>Vocational registrar</i>	563
<i>Continuing professional development</i>	565
References	566

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## Definition

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Doctors have long held a tradition of teaching. The Hippocratic Oath refers to the importance of teaching and mentoring.<sup>1</sup> Even the origins of the word ‘doctor’ come from the Old French for ‘teacher’, based on the Latin ‘docere’ (Oxford English Dictionary).

General practitioners possess many teaching skills that are often not recognised. All GPs educate their patients, and these teaching skills can be transferred to teaching medical students, general practice registrars, peers and health professionals. The skills for teaching can be acquired throughout the professional life, beginning in medical school.

Related to mentoring and teaching is leadership, which is being increasingly identified as a key skill vital to the success of healthcare, including general practice.<sup>2</sup>

Leadership involves setting a vision for people, and inspiring and setting organisational values and strategic direction.<sup>3</sup>

Leadership is different from management, which involves directing people and resources to achieve organisational goals set in place by leaders.<sup>3</sup>

While distinct, both leadership and management are critical to achieving organisational success.<sup>3</sup>

## Curriculum in practice

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The following scenarios illustrate how the teaching, mentoring and leadership curriculum applies to the general practice setting:

- Chris had believed the practice was too busy to become involved in teaching, until he was presented with a model that used vertical integration of curriculum between their registrar and a student who would be attached to the practice for 2 days a week for 12 months. The student was pre-trained in the use of medical software and presented cases through parallel consulting. This enabled the practice to maintain full clinical loads while still meeting the education and supervision needs of their trainees. The teaching is shared with an adjacent practice for some group sessions, which have enhanced overall collegiate relationships.
- Four years after arranging a practice swap, two doctors remain in a mentoring relationship separated by over 500 km. The experience has enabled a younger solo GP to remain in her small country town and to make changes that enable more sustainable practice. She has gone on to become a general practice supervisor and to mentor, in turn, a solo doctor in a more remote setting.
- The registrar in your practice is about to attend a clinical leadership event and wants to know your views on how leadership differs from management. Do you think there is also a difference between leadership in the hospital sector and in general practice? If so, why? Do you think that leadership is a skill that can be taught?

## Rationale and general practice context

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Professional codes of ethics highlight the professional obligation and tradition of passing on knowledge and skills to colleagues and students, for example, 'Honour your obligation to pass on your professional knowledge and skills to colleagues and students'.<sup>1</sup>

Teaching, mentoring and leadership roles are becoming a more common part of the everyday life of a general practice in the following ways:

- universities are directing learning away from the more traditional wards and lecture theatres of metropolitan tertiary hospitals, toward more community based settings, including general practices
- the advent of university departments of rural health and rural clinical schools in the early 21st century has seen much medical undergraduate education moved out of metropolitan centres to rural centres
- general practice vocational training has become regionalised, requiring an increasing number of teaching practices and supervisors, trainers and mentors in regional and rural Australia
- the general practice infrastructure of divisions of general practice has mainstreamed local delivery of continuing professional development
- the decentralisation of general practice education and the rise in numbers of general practice Fellows has resulted in general practice teaching and mentoring becoming a significant career path for any GP, as either a supervisor or a medical educator
- the increasing complexity of primary healthcare, the rise of quality improvement and innovation, and the move toward multidisciplinary approaches to patient care require increasing levels of leadership skills at all levels of the general practice learning life.

### Educational and leadership skills of GPs

General practitioners need to develop educational and leadership skills as an integral part of their professional repertoire. The skill sets detailed in this curriculum overlap and are required by all doctors throughout each stage of the learning life. The statement also provides a guide to extension skills and learning objectives to encourage those interested in furthering a career in teaching and mentoring in general practice, in addition to developing leadership skills.

Examples of typical skill requirements that extend across teaching, mentoring and leadership (especially within a general practice clinical context) include:

- understanding the roles of teachers, mentors and leaders – when to teach and when to learn, when to lead and when to follow
- incorporating teaching, mentoring and leadership at all levels of the learning life and within an organisation
- assessment and evaluation skills
- understanding adult learning principles and different learning styles
- instructional and supervision skills
- providing feedback
- teaching and leading individuals, groups (small and large) and organisations
- ethical approaches to teaching, mentoring and leading
- skills for teaching, mentoring and leading in complex environments, especially within the context of primary care
- change management skills
- incorporating diversity into teaching, mentoring and leading, eg. in rural settings, the role of gender, culturally and linguistically diversity, Aboriginal and Torres Strait Islander settings.

## Medical students — teaching, mentoring and leading

Equipping students with teaching and learning skills helps students to self direct their learning.

Programs concentrating on clinically focused topics, evidence based medicine and physical examination skills in both conventional and problem based contexts have proven to be beneficial for all students, both teachers and learners.

Peer tutoring is an educational strategy whereby student tutors – usually senior medical students – take on the helping role that facilitates first year students in activities by enabling them to support each others learning in undergraduate studies. This also helps develop team based work strategies, which lay the foundation for leadership roles, multidisciplinary care and teamwork.

## Prevocational doctors — teaching, mentoring and leading

Prevocational doctors spend a significant proportion of their work time in teams leading and educating junior medical staff and medical students.

Prevocational residents also demonstrate teaching style preferences that indicate the need for education in this skills area. Often didactic approaches are used, rather than developing learner problem solving skills, and feedback is rarely used for educational purposes. They prefer to question learners rather than engage in educational discourses, demonstrate techniques and procedures, and reference literature only minimally.<sup>4</sup>

Several key features of teaching and mentoring skills required by graduates at this stage or hospital resident level have been identified. In particular, prevocational doctors:

- spend 20–25% of time teaching
- enjoy teaching and consider it vital for their own education, not only in clinical skills but also in their own self directed learning skills and motivation
- recognise the importance of teaching to the profession
- often have little formal instruction as educators
- would prefer to spend more time teaching than they do
- lack confidence teaching when they need education in areas taught
- demonstrate improvement in teaching skills when they are given formal tuition in teaching
- demonstrate improvement in clinical skills and knowledge, although this cannot be directly attributable to the teaching skills program alone.

Teacher training is therefore recommended for all doctors in their postgraduate hospital years.

The presence of leadership skills has been linked to the provisions of high quality care, especially within complex systems by helping ensure that the patient is the central focus of multidisciplinary care.

## Vocational doctors – teachers, learners and leaders

Both the teacher and learner benefit from peer assisted learning. Universities are encouraging vertical integration of medical education, and general practice trainees are increasingly likely to experience roles in teaching medical students within the practices where they work. Some vocational trainees also choose to undertake an academic post at a university in which they are expected to teach medical students on campus.

Apart from student teaching, vocational trainees may frequently be involved with teaching peers and other health professionals within the training context. This may occur in workshop settings, small study groups, in individual instruction or clinical practice. Vocational trainees are also a valuable learning resource for their supervisors.

Leadership styles in the general practice setting are diverse, as most leadership models have been developed in large organisations and may not directly apply to the smaller general practice setting. Vocational training provides an opportunity to explore personal strengths and weaknesses, appreciate the role of leadership in the general practice and adapt personal leadership qualities to the primary care setting within the context of increasingly team based and multidisciplinary approaches.

## Postvocational doctors – teachers, mentors and leaders

General practitioners need to develop, maintain and expand skills as trainers, educators, mentors, researchers and leaders over their professional lifetime.

Many GPs will be involved in a variety of teaching roles, eg. staff education or educating medical students (in their practice or in a more formal academic setting), postvocational doctors and colleagues in a peer education process or in ‘train the trainer’ settings.

Effective teaching demands ongoing review of educational skills, and professional development programs need to consider and review the level of teaching skills required in order to develop and maintain teaching skills to the appropriate standards.

Being involved as a clinical leader is seen as a critical aspect of continuous quality improvement within the practice setting

## Related curriculum areas

Refer also to the curriculum statement:

- *Philosophy and foundation of general practice.*

# Training outcomes of the five domains of general practice

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## 1. Communication skills and the patient-doctor relationship

- TMLT1.1 Use good communication skills to ensure that educational and instructional messages are understood.
- TMLT1.2 Listen to the learner's needs to ensure that teaching occurs at the appropriate level and in the appropriate context.
- TMLT1.3 Use appropriate feedback when teaching, mentoring and leading in general practice.
- TMLT1.4 Recognise that the learner-teacher relationship is the most important factor in the effectiveness of the supervision.
- TMLT1.5 Use reflection and discussion as learning tools in general practice.
- TMLT1.6 Acquire good interviewing and facilitation skills.

## 2. Applied professional knowledge and skills

- TMLT2.1 Use educational and teaching skills when educating patients about treatment, eg. treatment adherence and lifestyle measures.
- TMLT2.2 Have specific knowledge and skills about teaching, learning and leadership, and understand that clinical skills and knowledge are not necessarily enough to be an effective teacher or leader.
- TMLT2.3 Maintain current and adequate clinical knowledge of the proposed teaching topic.
- TMLT2.4 Undertake and provide instruction and practice in teaching skill throughout all stages of medical and general practice training.
- TMLT2.5 Be aware of the range of learning styles, and be able to adjust teaching methods appropriately.
- TMLT2.6 Understand adult learning principles and learning styles.
- TMLT2.7 Use evidence based approaches to teaching.
- TMLT2.8 Be aware of the nature of leadership in the clinical setting.

## 3. Population health and the context of general practice

- TMLT3.1 Apply teaching skills and learning resources effectively when educating patients about preventive care and lifestyle information during consultations.
- TMLT3.2 Educate the community when promoting the benefits of population based health strategies or in community education.
- TMLT3.3 Understand the impact of diversity on teaching, mentoring and leading, eg. for those in rural settings, the role of gender, for people from culturally and linguistically diverse backgrounds and in Aboriginal and Torres Strait Islander settings.
- TMLT3.4 Recognise and incorporate the complexity of general practice into teaching mentoring and leading.

## 4. Professional and ethical role

- TMLT4.1 Understand the roles of teachers, mentors and leaders across the doctors learning life, eg. when to teach, when to learn, when to lead and when to follow.
- TMLT4.2 Be able to learn within group settings and work within teams.
- TMLT4.3 Respect the professional obligation of passing on knowledge and skills to colleagues and students.
- TMLT4.4 Recognise that teaching and mentoring require a degree of sharing of the teacher's clinical expertise.
- TMLT4.5 Focus teaching aims to improve patient outcomes and never to the detriment of the patient.
- TMLT4.6 Understand that an effective teacher recognises their own limits (both in clinical and teaching skills) and knowledge.
- TMLT4.7 Show enthusiasm for teaching, learning and general practice.
- TMLT4.8 Incorporate ethical approaches into teaching, mentoring and leading.

## 5. Organisational and legal dimensions

- TMLT5.1 Set aside and protect teaching time from other intrusions.
- TMLT5.2 Ensure that the learning environment promotes effective teaching and learning, including online teaching.
- TMLT5.3 Maintain overall responsibility for the patient's care when supervising clinician teaching, although the learners may be given increasing responsibility in patient care.
- TMLT5.4 Be available, accessible and approachable for effective teaching and supervision in general practice.
- TMLT5.5 Recognise the role of teaching, mentoring and leadership in change management.

# Learning objectives across the GP professional life

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## Medical student

### 1. Communication skills and the patient-doctor relationship

- TMLLM1.1 Demonstrate ability to respond to the personal learning problems, challenges and triumphs of others.
- TMLLM1.2 Demonstrate awareness of the influence of personal feelings on the student's learning behaviour.
- TMLLM1.3 Describe how to build on one's own learning and leadership strengths.
- TMLLM1.4 When involved in teaching, demonstrate how to offer constructive feedback on other students' learning progress.
- TMLLM1.5 Where appropriate, demonstrate involvement in activities that enable students to support each other's learning in undergraduate studies.

### 2. Applied professional knowledge and skills

- TMLLM2.1 Describe the differences and relationships between teaching, mentoring and leadership skills.
- TMLLM2.2 Demonstrate how to make learning contracts.
- TMLLM2.3 Describe adult learning principles.
- TMLLM2.4 Demonstrate appropriate knowledge and experience of subject areas to be effective in teaching.
- TMLLM2.5 Demonstrate provision of reliable evidence based current information and resources.
- TMLLM2.6 Demonstrate effective interviewing and facilitation skills.
- TMLLM2.7 Integrate a variety of interactive teaching methods to engage students, including discussion, interactive lectures using computer based presentations and other audiovisual aids, and small group breakout sessions.
- TMLLM2.8 Describe how to self critique each session.
- TMLLM2.9 Reflect on the effectiveness of the chosen teaching methods.
- TMLLM2.10 Describe the nature and impact of leadership, especially within the clinical setting.

### 3. Population health and the context of general practice

- TMLLM3.1 Identify sociocultural and other population health factors, which may inhibit learning and prevent undertaking leadership roles.
- TMLLM3.2 Describe the relevance of the learning experience to the student and how this could vary according to a student's background.
- TMLLM3.3 Describe the use of teaching and learning into clinical practice to assist patient behaviour change.

## 4. Professional and ethical role

- TMLLM4.1 Demonstrate insight into personal learning gaps.
- TMLLM4.2 Demonstrate the ability to change between the roles of student and teacher, and the roles of leader and follower.
- TMLLM4.3 Develop peer support systems for students.
- TMLLM4.4 Encourage peer support and learning through self role-modelling.
- TMLLM4.5 Encourage reflection by students.
- TMLLM4.6 Describe the importance of learning to recognise one's own limits.
- TMLLM4.7 Structure a learning plan to address identified gaps in knowledge or skills.
- TMLLM4.8 Encourage students to participate in planning curriculum.
- TMLLM4.9 Develop educational activities in collaboration with a supervising mentor academic.
- TMLLM4.10 Encourage and support student discussion and clinical questioning on a peer-to-peer basis.
- TMLLM4.11 Describe the professional roles of doctors in teams.
- TMLLM4.12 Outline the professional importance of teaching.

## 5. Organisational and legal dimensions

- TMLLM5.1 Demonstrate how to organise time to enable student-teacher access and discussion.
- TMLLM5.2 Work in collaboration with academic teachers, peers and teams.
- TMLLM5.3 Undertake assessment of student learning and course materials.
- TMLLM5.4 Discuss teamwork in teaching, learning, mentoring and leadership.

# Learning objectives across the GP professional life

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## Prevocational doctor

Assumed level of knowledge – medical student

### 1. Communication skills and the patient-doctor relationship

- TMLLP1.1 Demonstrate a sound understanding of the application of communication skills in the teaching, mentoring and leadership context, particularly in the areas of:
  - TMLLP1.1.1 developing and maintaining rapport
  - TMLLP1.1.2 empathy
  - TMLLP1.1.3 communicating a nonjudgmental, respectful and supportive attitude
  - TMLLP1.1.4 appropriate use of nonverbal behaviour
  - TMLLP1.1.5 articulating context, intent and planning (what's happening, and what will happen next)
  - TMLLP1.1.6 code switching, as in addressing different audiences (patient, family members, staff, students, leaders).
- TMLLP1.2 Demonstrate a sound understanding of the application of communication skills in the teaching role, particularly in:
  - TMLLP1.2.1 facilitating learning as well as delivering content
  - TMLLP1.2.2 supporting student centred learning as well as delivering a normative curriculum
  - TMLLP1.2.3 mentoring students and offering a learning role model as well as teaching clinical skills
  - TMLLP1.2.4 developing and offering a safe, supportive learning environment.
- TMLLP1.3 Demonstrate an inclusive, team based communication approach to teaching and leadership that, where appropriate, involves:
  - TMLLP1.3.1 orienting students to the learning environment
  - TMLLP1.3.2 orienting staff and patients to the student's role
  - TMLLP1.3.3 orienting students, staff and patients to the teacher's role
  - TMLLP1.3.4 communicating with the student as an integral member of the healthcare team
  - TMLLP1.3.5 clearly articulating team roles, responsibilities and expectations.

### 2. Applied professional knowledge and skills

- TMLLP2.1 Apply adult learning principles in the teaching context.
- TMLLP2.2 Assess the learning needs of students, particularly gaps in learner knowledge and skills.
- TMLLP2.3 Develop a teaching agenda that focuses on what students should learn (eg. normative curriculum) as well as what they want to learn (student centred learning intent), particularly by:
  - TMLLP2.3.1 assisting learners to 'learn' rather than you 'teaching' what you know
  - TMLLP2.3.2 drawing on the learner's own knowledge, skills and experience

	TMLLP2.3.3	supporting learner autonomy, and learner identification of the appropriate level of autonomy in the circumstance
	TMLLP2.3.4	allowing for variation in learning style.
TMLLP2.4		Develop learning objectives that enable the learner to understand what they need to achieve in terms of learning outcomes.
TMLLP2.5		Facilitate a student's progress through the compilation of a learning portfolio with particular reference to mentoring, including:
	TMLLP2.5.1	needs assessment
	TMLLP2.5.2	learning objectives and plan
	TMLLP2.5.3	periodic evaluation and formative feedback
	TMLLP2.5.4	systematic collection of evidence of learning
	TMLLP2.5.5	periodic revision of the learning plan
	TMLLP2.5.6	submission of the final portfolio.
TMLLP2.6		Structure a learning environment to enable learning objectives to be met, particularly by:
	TMLLP2.6.1	providing a safe environment for learning
	TMLLP2.6.2	managing work rounds to ensure time for teaching and learning
	TMLLP2.6.3	applying theory to real scenarios
	TMLLP2.6.4	facilitating opportunistic teaching and learning in the experiential setting.
TMLLP2.7		Structure an educational activity to enable learning objectives to be met, particularly by:
	TMLLP2.7.1	planning and structuring the learning experience in advance where possible (ie. specific patients, breakout opportunities, follow up group debrief)
	TMLLP2.7.2	structuring learner expectations so that learners know what they are expected to know as a result of any one learning unit or opportunity
	TMLLP2.7.3	communicating goals/objectives
	TMLLP2.7.4	adjusting teaching to the learning environment
	TMLLP2.7.5	giving positive and constructive feedback individually and in the group setting
	TMLLP2.7.6	using audiovisual and electronic teaching aids
	TMLLP2.7.7	providing follow up learning opportunities, eg. interpretation of tests, referral letters, references, URLs and self directed learning resources.
TMLLP2.8		Provide active learning opportunities for the learner by:
	TMLLP2.8.1	involving the learner in examination of the patient
	TMLLP2.8.2	involving the learner in discussion of the patient
	TMLLP2.8.3	asking or reflecting questions back to the learner
	TMLLP2.8.4	encouraging them to reflect on and assess the case and learning arising from it
	TMLLP2.8.5	supporting teaching with evidence, standards and guidelines
	TMLLP2.8.6	developing a learner's clinical problem solving skills
	TMLLP2.8.7	allowing time for practice of skills or procedure and provide feedback

- TMLLP2.8.8 providing guidance to appropriate reading materials
  - TMLLP2.8.9 providing feedback.
- TMLLP2.9 Demonstrate an understanding of the appropriate use of a range of teaching methods to enable learners to meet their learning needs and satisfy normative learning objectives, such as:
  - TMLLP2.9.1 lectures
  - TMLLP2.9.2 small group discussion, particularly to promote active learning and relationship building
  - TMLLP2.9.3 roleplays
  - TMLLP2.9.4 bedside teaching
  - TMLLP2.9.5 teaching in the clinic
  - TMLLP2.9.6 teaching microskills
  - TMLLP2.9.7 setting clear learning expectations
  - TMLLP2.9.8 discussing/questioning, asking questions that promote learning (eg. clarifications, Socratic questions, probes, reflective questions).
- TMLLP2.10 Motivate learners by:
  - TMLLP2.10.1 asking learners to commit to a diagnosis or plan
  - TMLLP2.10.2 probing for supporting evidence/thought processes
  - TMLLP2.10.3 directing attention
  - TMLLP2.10.4 psychomotor skills
  - TMLLP2.10.5 demonstrating techniques and teaching procedures
  - TMLLP2.10.6 checking for understanding and retention
  - TMLLP2.10.7 presentation skills, eg. lecture, small group, delivering information/teaching skills in short periods of time
  - TMLLP2.10.8 giving feedback, particularly on specific knowledge or skills or techniques or evidence
  - TMLLP2.10.9 inviting questions (now or later).
- TMLLP2.11 Structure an evaluation process that will enable improvement of the educational process, particularly in relation to:
  - TMLLP2.11.1 360 degree evaluation (student, faculty, self assessment)
  - TMLLP2.11.2 creating the agenda and opportunity for future learning
  - TMLLP2.11.3 offering quality assurance
  - TMLLP2.11.4 implementing assessment processes that will enable learning outcomes to be measured
  - TMLLP2.11.5 delivering content to the limit of their own knowledge and skills.

### 3. Population health and the context of general practice

- TMLLP3.1 Demonstrate the effective use of teaching skills and learning resources effectively when educating patients about preventive care and lifestyle information during consultations.
- TMLLP3.2 Describe the impact of patient diversity on educating patients in the clinical context, eg. those in rural settings, the role of gender, for people from culturally and linguistically diverse backgrounds, and in Aboriginal and Torres Strait Islander settings.

## 4. Professional and ethical role

- TMLLP4.1 Model professional and ethical behaviour as a teacher, mentor and leader.
- TMLLP4.2 Demonstrate a teaching focus that aims to improve patient outcomes and never to the detriment of the patient.
- TMLLP4.3 Manage interpersonal behaviour in a manner appropriate to the relevant teacher, mentor or leader roles and responsibilities.
- TMLLP4.4 Demonstrate an enthusiastic and motivational attitude to students and to teaching.
- TMLLP4.5 Demonstrate accountability for teaching and learning process and outcomes.
- TMLLP4.6 Structure an evaluation process that offers quality assurance to peers, faculty and students.
- TMLLP4.7 Identify the roles of teachers, mentors and leaders in the current clinical setting.
- TMLLP4.8 Demonstrate the ability to work as a leader and a follower within teams.
- TMLLP4.9 Incorporate ethical approaches into teaching, mentoring and leading in current clinical setting.

## 5. Organisational and legal dimensions

- TMLLP5.1 Manage time efficiently and effectively to enable both teaching and mentoring and caregiving in the clinical context.
- TMLLP5.2 Articulate, as required, the legal constraints and limitations of the teacher/mentor's role in the specific educational context, eg. privacy legislation and equal opportunity laws.
- TMLLP5.3 Outline how to make a learning environment promote effective teaching and learning within the current clinical context, including online environments.
- TMLLP5.4 Maintain overall responsibility for the patient's care when supervising clinician teaching, although the learners may be given increasing responsibility in patient care.
- TMLLP5.5 Recognise the role of teaching, mentoring and leadership in change management in the current clinical environment.

# Learning objectives across the GP professional life

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## Vocational registrar

Assumed level of knowledge – prevocational doctor

### 1. Communication skills and the patient-doctor relationship

- TMLLV1.1 Demonstrate basic teaching, mentoring and leadership skills including:
  - TMLLV1.1.1 clearly explaining to learners the reasoning behind the use of particular clinical strategies
  - TMLLV1.1.2 formulating appropriate questions to encourage learners to develop problem solving skills
  - TMLLV1.1.3 discussing and demonstrating strategies to help develop rapport with the learner/mentee/follower.
- TMLLV1.2 Demonstrate, where appropriate, extension teaching, mentoring and leadership skills, including:
  - TMLLV1.2.1 demonstrating the ability to provide constructive and specific feedback to learners, which challenges them to reflect and expand their skills
  - TMLLV1.2.2 demonstrating the appropriate use of the range of public presentation audiovisual aids and educational resource technology in delivering education to peers and undergraduates
  - TMLLV1.2.3 practising effective communication skills for facilitating learning within one-to-one, small group and larger group contexts.

### 2. Applied professional knowledge and skills

- TMLLV2.1 Divide tasks or knowledge into manageable portions to improve learning opportunities.
- TMLLV2.2 Identify the level at which learning needs to occur for different learners.
- TMLLV2.3 Develop personal learning plans and objectives based on identification of learning needs and development of learning activities and strategies to fulfil these objectives.

### 3. Population health and the context of general practice

- TMLLV3.1 Explain the characteristics of a nurturing environment, which encourages learning and professional development.
- TMLLV3.2 Identify factors that may inhibit learning and discuss strategies suitable to address them.
- TMLLV3.3 Demonstrate the effective use of teaching skills and learning resources effectively when educating patients about preventive care and lifestyle information during general practice consultations.
- TMLLV3.4 Describe the impact of patient diversity on educating patients in the general practice context, eg. those in rural settings, the role of gender, for people from culturally and linguistically diverse backgrounds, and in Aboriginal and Torres Strait Islander settings.

## 4. Professional and ethical role

- TMLLV4.1 Explain circumstances that would demonstrate appropriate supervision of learners and in leadership roles.
- TMLLV4.2 Demonstrate appropriate professional and leadership roles to learners.
- TMLLV4.3 Model appropriate attitudes to learning, leadership and professionalism.
- TMLLV4.4 Identify own limits when teaching others.
- TMLLV4.5 Outline setting and maintaining appropriate, clear role boundaries.
- TMLLV4.6 Discuss strategies that can be used to stimulate learning and encourage reflection.
- TMLLV4.7 Describe the roles and responsibilities of a clinical leader.

## 5. Organisational and legal dimensions

- TMLLV5.1 Identify and create suitable learning opportunities within consultations.
- TMLLV5.2 Explain how to obtain patient consent for the teaching process within the consultation.
- TMLLV5.3 Arrange for sufficient time for discussion.
- TMLLV5.4 Describe the legislative requirements associated with teaching and learning, such as copyright, privacy and public lending rights.
- TMLLV5.5 Outline the responsibilities and requirements involved when undertaking teaching within the general practice setting as appropriate.

# Learning objectives across the GP professional life

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## Continuing professional development

Assumed level of knowledge – vocational registrar

### 1. Communication skills and the patient-doctor relationship

- TMLLC1.1 Consider continuing education on communication skills for effective teaching.
- TMLLC1.2 Demonstrate ability to provide effective feedback to learners.
- TMLLC1.3 Outline the communication skills involved in being a leader and a follower.

### 2. Applied professional knowledge and skills

- TMLLC2.1 Describe a range of teaching techniques and their appropriateness to different settings.
- TMLLC2.2 Develop further skills in teaching.
- TMLLC2.3 Demonstrate the ability to assess and deal with students needing further assistance (eg. remediation).
- TMLLC2.4 Outline the skills required for a clinical leader within the current practice setting.

### 3. Population health and the context of general practice

- TMLLC3.1 Describe differences in individual needs and learning styles between students and registrars and demonstrate ability to adapt to those differences.

### 4. Professional and ethical role

- TMLLC4.1 Become involved in a network of teachers, professional educator organisations and education providers to encourage further skills development.
- TMLLC4.2 Demonstrate awareness of potential conflicts that may occur with an increasing variety of roles, eg. teacher, employer, supervisor, examiner, GP, leader.
- TMLLC4.3 Describe the role of being alert to one's own limitations in teaching skills and be able to involve others if needed.
- TMLLC4.4 Identify personal clinical leadership roles within the current clinical setting and their role in quality improvement and team based care.

### 5. Organisational and legal dimensions

- TMLLC5.1 Describe the effects of teaching on the running of a general practice in terms of space, time and finances.
- TMLLC5.2 Outline the role of online delivery in teaching, mentoring and leadership.
- TMLLC5.3 Recognise the need for ongoing support and resources from organisations involved in training and education.
- TMLLC5.4 Identify organisational personal leadership roles within the current clinical setting and their role in quality improvement and team based care.
- TMLLC5.5 Incorporate clinical leadership roles into quality improvement cycles.

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