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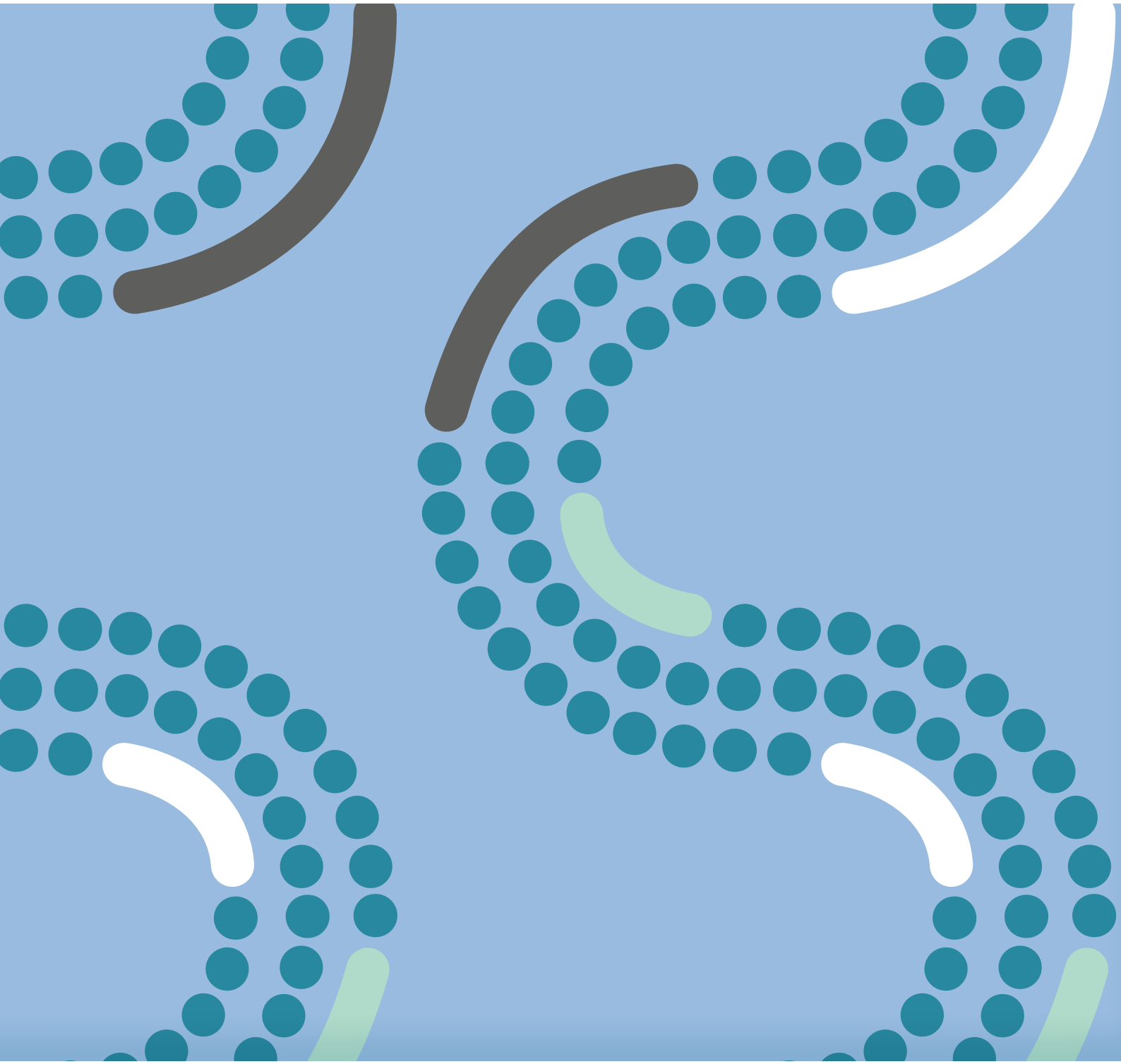
Royal Australian College *of* General Practitioners

Curriculum for Australian General Practice 2016

CS16 Core skills unit



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Curriculum for Australian General Practice 2016 – CS16 Core skills unit

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We recognise the traditional custodians of the land and sea on which we work and live.

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Introduction

The core skills that form the centrepiece of the Curriculum for Australian General Practice clearly state, in measurable terms, the knowledge and skills required for each stage of general practice training. The unit was developed by identifying the unifying elements in each of the former curriculum statements that collectively defined the core skills and the unique nature of the Australian general practitioner (GP).

The development of this unit has been an organic process. It evolved throughout the Curriculum review process as a result of subject matter experts, stakeholders, medical writers and editors recognising that there was significant repetition in the existing curriculum, which could be addressed by the identification and articulation of the core skills.

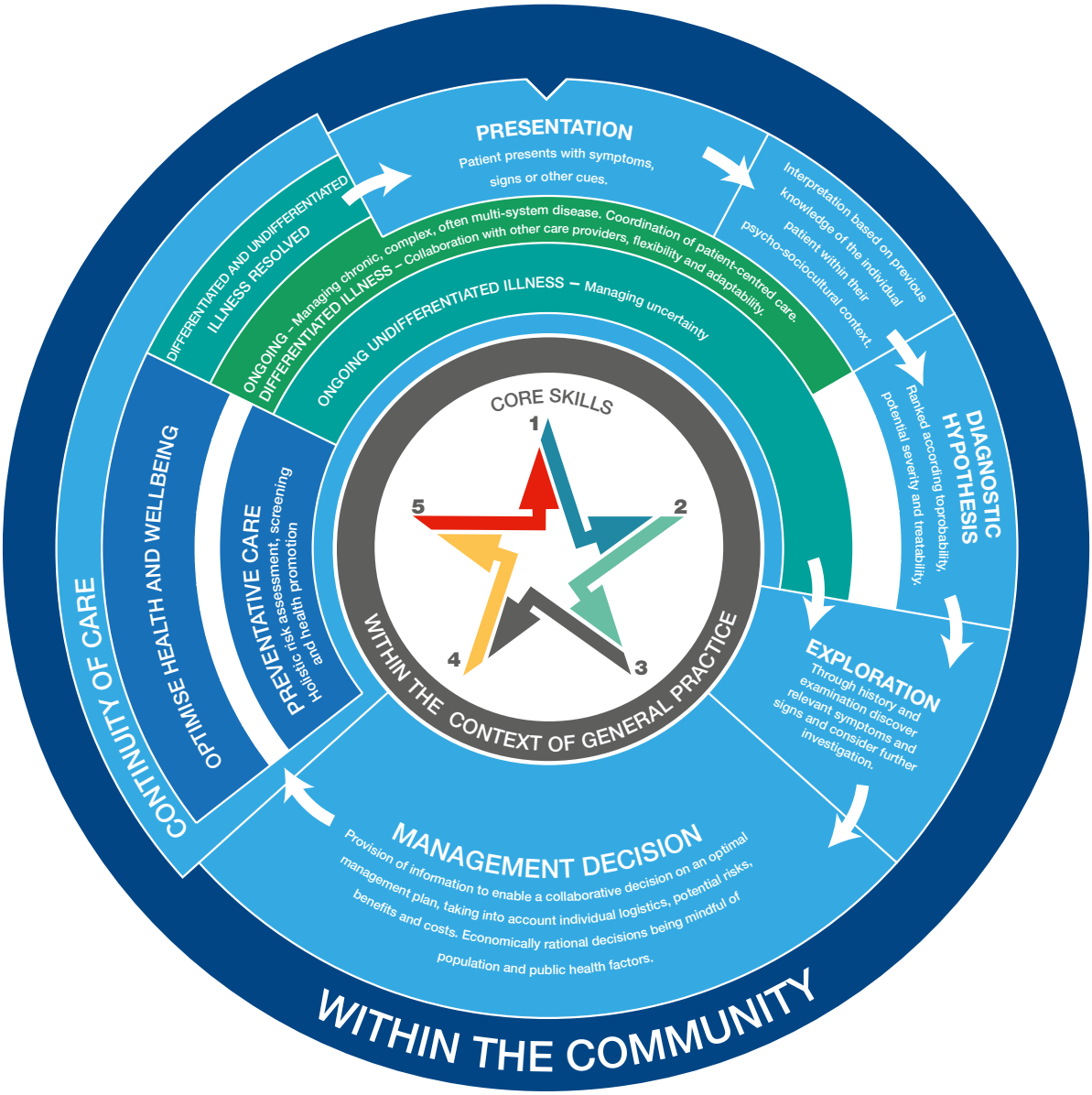
The Core skills unit, in combination with specific units in Rural health and Aboriginal and Torres Strait Islander health, now constitutes the Curriculum for Australian General Practice, replacing the 36 statements that made up the 2011 Curriculum. The broad variety of groups of important conditions and unique populations that constituted the former curriculum statements in the 2011 Curriculum for Australian General Practice are maintained as curriculum support materials. These population, presentation and process contextual unit statements are made up of a rationale for the importance of inclusion of this subject area in the skills framework and contain regularly updated references. By separating the core skills from the populations and presentations to which they can be applied, the opportunity has opened up to develop more resource materials for additional populations and presentations as the need arises.

An important change to the format of the Curriculum for Australian General Practice is the reduction of the four learning pathways to three. They have been divided into 'Pre-general practice' (refers to medical students and doctors who have not entered into any of the formal general practice training pathways), 'General practice under supervision' (eg pre-Fellow GPs enrolled in a training pathway) and 'General practice – lifelong learning' (eg GPs who hold Fellowship of the RACGP [FRACGP] or Fellowship of the Australian College of Rural and Remote Medicine [FACRRM], or who are vocationally registered).

The Core skills unit is designed to assist the RACGP, regional training organisations (RTOs), Quality Improvement and Continuing Professional Development (QI&CPD) providers, specific interest groups, general practice supervisors and other users of the Curriculum to design learning programs, courses, and assessments to meet the stated outcomes and criteria. In conjunction with the Competency Profile of the Australian General Practitioner, the Core skills unit will also provide guidance for those who assess overseas doctors on alternate pathways and doctors wishing to be recognised as eligible for the FRACGP.

The nature of competency-based education means that the outcomes and criteria outlined in the Curriculum are broad. This in turn enables training providers to develop the processes that enable the outcomes and criteria to be met within the context of where, when, how and to whom the training is delivered. The 'range statement' provides further detail of the terminology used, providing examples of how the outcomes and criteria can be brought to life in a variety of ways. This curriculum is not a syllabus nor an exhaustive list of all of the knowledge and skills required to work as a GP, but should rather be viewed as the foundations upon which more detailed learning programs are developed.

High level problem solving in general practice consultations



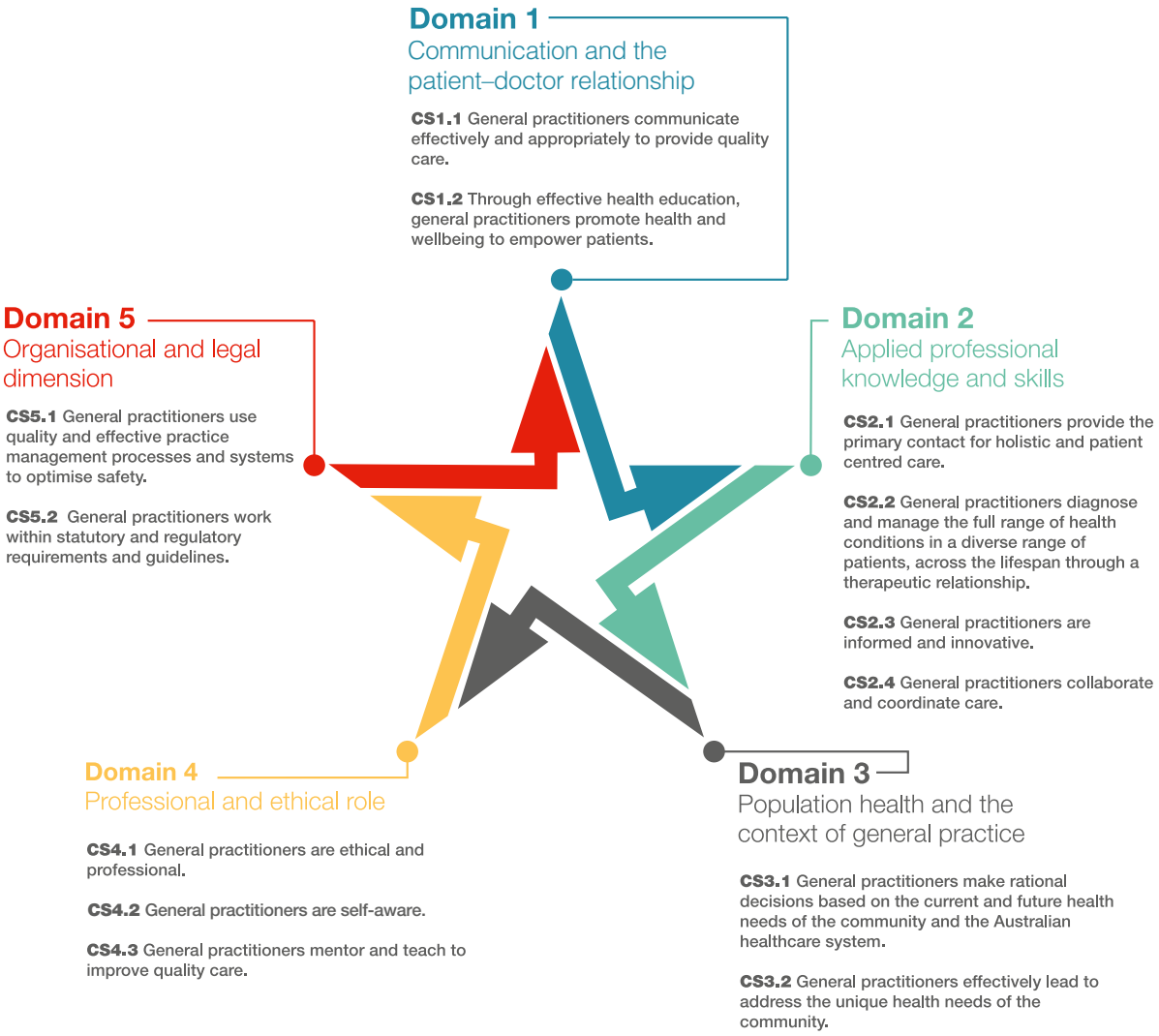
CONTEXT OF GENERAL PRACTICE

Broad range of patients presenting with broad range of conditions across the lifespan.

High incidence of transient and undifferentiated illness. High prevalence of chronic, complex and multisystem illness. High incidence of psychological illness and psychological factors contributing to presentations.

1. Communication and the patient–doctor relationship
2. Applied professional knowledge and skills
3. Population health and the context of general practice
4. Professional and ethical role
5. Organisational and legal dimension

Core skills – the star of general practice



CS16 Core skills unit

Domain 1. Communication and the patient–doctor relationship

'It is more important to know what sort of person has the disease than to know what sort of disease the person has' – Hippocrates

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
CS1.1 GPs *communicate effectively and appropriately to provide quality care*	**CS1.1.1** Communication is clear, respectful, empathic and appropriate to the person and their *sociocultural context*	**CS1.1.1.1a** Communicate effectively with a *range of patients*	**CS1.1.1.1b** Use effective communication skills with a broad *range of patients* in the general practice setting	**CS1.1.1.1c** Reflect on communication style to identify areas for improvement
		CS1.1.1.2a *Empathy and sensitivity* are consistently demonstrated	**CS1.1.1.2b** Identify and manage *barriers to effective communication*	**CS1.1.1.2c** Develop *cultural competence* with a broad range of patients
		CS1.1.1.3a Identify *factors that may impact effective communication*	**CS1.1.1.3b** Develop strategies for cultural safety, to explore and integrate *sociocultural context into consultations*	**CS1.1.1.3c** Provide mentoring for junior colleagues regarding effective communication
		CS1.1.1.4a Describe *strategies to overcome barriers to communication*	**CS1.1.1.4b** Identify situations where *effective use of empathy and sensitivity could improve outcomes*	**CS1.1.1.4c** Review practice processes to improve the quality of communication for patients in the practice
		CS1.1.1.5a Identify the factors to optimise communication when professional interpreters are used	**CS1.1.1.5b** Effectively utilise *professional interpreter services*	**CS1.1.1.5c** Review and enhance the use of empathy and sensitivity in consultations
				CS1.1.1.6c Review practice use of professional interpreters
	CS1.1.2 Effective communication is used in *challenging situations*	**CS1.1.2.1a** Outline the key *factors to consider when breaking bad news*	**CS1.1.2.1b** Formulate strategies to assist in *breaking bad news*	**CS1.1.2.1c** Review and implement strategies to *optimise safety of staff* from aggressive patients
		CS1.1.2.2a Identify and effectively manage patients who are *distressed or agitated*	**CS1.1.2.2b** Assess and effectively manage an *agitated patient or family member*	

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
		CS1.1.2.3a Identify *patients who may be experiencing consequences of trauma*	**CS1.1.2.3b** Sensitively discuss *prognosis and end-of-life decisions*	
			CS1.1.2.4b Identify and sensitively manage patients experiencing *current or consequences of trauma*	
	CS1.1.3 Communication with *family, carers and others* involved in the care of the patient is appropriate and clear	**CS1.1.3.1a** Identify patients whose care may be enhanced by communication with carers or family members	**CS1.1.3.1b** Identify and manage potential difficulties regarding involvement of family members and/or carers	**CS1.1.3.1c** Implement strategies to mentor and support colleagues regarding ethical and effective communication with family members and/or carers
		CS1.1.3.2a Identify situations where the involvement of family or carers may be detrimental to the care of the patient	**CS1.1.3.2b** Communicate appropriately and ethically with family members to obtain corroborating medical history	**CS1.1.3.2c** Develop practice guidelines for the involvement of and disclosure to family members and carers
		CS1.1.3.3a Utilise *ethical strategies* to manage confidentiality and to obtain informed consent prior to communication with family members and/or carers and/or others.	**CS1.1.3.3b** Appropriately engage and communicate with care givers in *management plan* discussions	
		CS1.1.3.4a Develop communication strategies to assist in breaking bad news to carers and family members	**CS1.1.3.4b** Identify and manage *impacts of burden of care* on carers	
			CS1.1.3.5b Effectively break bad news to family members and carers	
	CS1.1.4 Complaints and concerns are managed effectively	**CS1.1.4.1a** Identify cues that suggest a patient may have concerns or issues regarding their care	**CS1.1.4.1b** Utilise *effective problem-solving approaches* to address patient complaints	**CS1.1.4.1c** Support and mentor colleagues for whom patient complaints have arisen

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
		CS1.1.4.2a Analyse and propose management strategies in clinical scenarios where issues have arisen	**CS1.1.4.2b** Appraise and review management of patient complaints to determine if future improvements could be made	**CS1.1.4.2c** Enhance problem-solving skills to optimise resolution of patient and staff complaints
			CS1.1.4.3b Formulate strategies to reduce risk of issues or complaints arising in the future	**CS1.1.4.3c** Provide support for staff involved in complaint management
			CS1.1.4.4b Facilitate access to *external resources* if outcome of concerns is unsatisfactory	**CS1.1.4.4c** Review *practice structures for managing complaints effectively*
CS1.2 GPs use effective health education to promote health and wellbeing to empower patients	**CS1.2.1** Ways in which health can be optimised and maintained are communicated to patients, family members and carers	**CS1.2.1.1a** Identify *patients who would benefit from health promotion education* to optimise health outcomes	**CS1.2.1.1b** Identify *opportunities to effect positive change through health education and promotion*	**CS1.2.1.1c** Review health education resources and ensure that they are relevant and up to date
		CS1.2.1.2a Describe possible *barriers to patients implementing important health promotion and self-care activities*	**CS1.2.1.2b** Provide *opportunistic, effective counselling about normal life stages* to optimise wellbeing	**CS1.2.1.2c** Use a variety of strategies with individuals with *different health belief systems*, to explain the *biomedical model* treatment approaches
		CS1.2.1.3a Identify patients who would benefit from *opportunistic life-stage counselling* and health education	**CS1.2.1.3b** Identify and *address barriers to patients implementing health promotion and self-care activities* into daily life	
			CS1.2.1.4b Identify and address *gaps in health education resources*	
			CS1.2.1.5b Utilise *appropriate strategies* to motivate and assist patients in maintaining healthy behaviours	

Context and application: Domain 1

CS1.1 ***Communicate effectively and appropriately to provide quality care*** – includes the use of socioculturally appropriate (eg age, developmental stage and gender-specific communication to relate effectively), and non-judgemental verbal and non-verbal cues to communicate sensitively but efficiently to obtain and share important information. Effective communication is an essential component of quality general practice to enable effective history taking, facilitate physical examination, discuss investigations, diagnosis and management, and ultimately to encourage improved health outcomes through collaborative continuity of care.

Through ongoing continuity of care, GPs often develop a comprehensive understanding of their patients and are thus uniquely situated to identify patient verbal and non-verbal cues (which may identify important issues such as exposure to violence and abuse). This knowledge and establishment of trust, gained through continuity of care, is the basis of an effective therapeutic relationship. The development of a respectful therapeutic relationship usually involves empathy and sensitivity where the GP makes an effort to see things from the perspective of the patient, validates that perspective to enable patient-centred quality diagnosis and management to be initiated, and effective collaboration through provision of appropriate health education and consequent shared, informed decision making.

Effective communication is the culmination of a number of important skills and attitudes, including:

- being respectful, empathic and sensitive
- utilising attentive listening (active and reflective)
- humility
- effective use of silence and open questions
- acknowledgement of the patient's level of health literacy and modification of language to match
- other non-verbal communication, such as body language, eye contact and appropriate touch.

Utilisation of other strategies, such as reflection, regularly 'checking back' with patients, summarising issues discussed, management plans and provision of appropriate health information, are all important.

Evaluation of an individual's level of health literacy and acknowledgement of the existence of any power imbalance in the therapeutic relationship is an important step to enable rapport and trust to be established prior to the provision of health information through verbal, electronic or paper-based means. This will more readily enable effective health education, communication of risks and consequent utilisation of motivational and/or supportive counselling to encourage behavioural change with the aim of optimising health outcomes.

Another aspect of effective communication is being mindful that patients of Aboriginal and Torres Strait Islander and other culturally and linguistically diverse (CALD) backgrounds, individuals with cognitive or sensory impairments or with limited health literacy and other vulnerabilities (such as mental illness, history of trauma, substance use issues, etc) have the same rights to quality healthcare as everyone else, and the right to the same respect and courtesy. This attitude can be demonstrated by maintaining a person-centred approach through techniques such as the development of cultural awareness and competency, effective use of interpreters where appropriate, speaking directly to the person (even when an interpreter is being utilised), using an age-appropriate tone of voice, appropriate scheduling of long appointments, etc.

Appropriate communication with family, carers, health professionals and others takes into account duty of care responsibilities, particularly in regards to confidentiality and respect for patient autonomy, as well as the provision of concise and meaningful information to optimise collaborative care and thus clinical outcomes.

Useful resource

- Warnecke E. The art of communication. Aust Fam Physician 2014;43(3):156–58, www.racgp.org.au/afp/2014/march/art-of-communication

CS1.1.1 ***Sociocultural context*** – has a broad range of meanings, but generally refers to an individual's 'way of life'. This context may be described as the influences which can impact an individual's behaviour, perspective, choices, health and spiritual beliefs (including use of traditional medicines), values and risk classification to varying degrees. Factors to consider when assessing an individual's sociocultural context include:

- determination of Aboriginal and Torres Strait Islander status
- race/ethnicity
- gender identity
- sexuality
- religious beliefs (may have relevance to choice of medical procedures and acceptable managements)
- socioeconomic status
- family connections and traditions
- peer groups
- occupation
- age.

It is important not to make assumptions about an individual's sociocultural context based on their appearance. The most reliable way to determine the potential influences on an individual's health beliefs and values is through sensitive, open and respectful questioning. Health beliefs may arise from traditional healing systems that may utilise a number of modalities, such as mind–body medicine, dietary advice, acupuncture and herbal medicines, to address health problems (eg Ayurvedic Indian medicine, traditional Chinese medicine and traditional healing systems used by the Aboriginal and Torres Strait Islander peoples gathered from thousands of years of empirical knowledge and clinical experience).

CS1.1.1.1a ***Range of patients*** – refers to the broad range of individuals who may present to general practice. This includes:

- age ranges and life stages of development
- different levels of physical, emotional and intellectual ability
- acute, chronic and preventive health presentations and impairments affecting any body system or combination of systems (to comply with the RACGP definition of general practice and the requirements for completion of the training program)
- gender
- socioeconomic and health literacy backgrounds
- culturally and linguistically diverse backgrounds
- diversity of religion, sexuality and occupation.

CS1.1.1.2a ***Empathy and sensitivity*** – may be expressed verbally and/or non-verbally to indicate a GP's understanding of the patient's feelings through an open and non-judgemental approach. Empathy and sensitivity may be defined as demonstrating the ability to sense what other people are experiencing emotionally and/or spiritually, combined with the ability to imagine what the individual may be thinking or feeling based on understanding of their personality, previous experiences, sociocultural context and belief systems. Empathy may be demonstrated by a GP through the use of active listening, considering influences of personality, sociocultural context, previous experience and level of health literacy, as well as acknowledging and, if appropriate, validating the patient's belief systems.

CS1.1.1.3a *Factors that may impact effective communication* – includes:

- patients who speak English as a second language and the importance of recognition of the need to engage professional interpreters (either onsite or by phone)
- inadequate provision of time for consultation with individuals of culturally and linguistically diverse backgrounds and/or low health literacy
- failure to recognise impacts of cognitive and/or sensory impairments on ability to communicate and process information
- recognition of different health beliefs stemming from cultural, spiritual or religious backgrounds (eg the need for gender-concordant care)
- failure of the GP to recognise and manage their own cultural bias and cultural lens, which can have potentially negative impacts on the quality of communication and, thus, on the future ability to work collaboratively with individuals
- recognition that individuals with sensory or cognitive impairment may require different communication styles and strategies.

Useful resources

- Britt H, Valenti L, Miller G. Determinants of consultation length in Australian general practice. Med J Aust 2005;183(2):68–71, www.mja.com.au/journal/2005/183/2/determinants-consultation-length-australian-general-practice
- Harrison C, Britt H, Charles J. Sex of the GP – 20 years on. Med J Aust 2011;195(4):192–96, www.mja.com.au/journal/2011/195/4/sex-gp-20-year

CS1.1.1.4a *Strategies to overcome barriers to communication* – includes non-judgemental acknowledgement of gender, cultural and sexual diversity, which is an essential component of effectively incorporating sociocultural context into consultations. Assessment of an individual's health literacy is another important consideration within sociocultural context which will assist the GP in presenting information in a way which will be readily understood to enable effective engagement and a collaborative approach to care. Acknowledgement of own cultural lens and cultural bias, utilising empathy and sensitivity to deliver person-centred care which is culturally safe, are all important strategies to incorporate into routine care.

Undertaking a 'cultural assessment' is a valuable way to establish any important cultural influences on an individual's health beliefs and consequent decision making. The basic premise of cultural assessments is that patients have a right to their cultural beliefs, values and practices, and these factors should be understood, respected, and considered when giving culturally competent care. A comprehensive cultural assessment allows the practitioner to gain an understanding of how embedded the individual is in their culture and its belief system, which may be gained through asking about migration history and whether this was involuntary or voluntary, whether they live in an area with many people of the same culture, which traditions they follow (ie accessing traditional healers and therapies), learning about the meaning of the illness in terms of the patient's cultural lens (eg what they think has caused their illness and their expectations of treatment and care), etc.

CS1.1.1.2b *Manage barriers to effective communication* – barriers may include social, language and cultural barriers that can be exacerbated by a GP displaying ignorance, cultural incompetence or disrespect. This can lead to the GP failing to recognise the impact of social and/or language differences on the therapeutic relationship, patient fear and mistrust of mainstream health services due to previous experiences, low levels of health literacy, provision of inadequate time for complex consultations, and cultural factors which may impact on communication and an individual's ability to engage with health services.

Other barriers may include individual perceptions of power imbalances, failing to acknowledge financial concerns, other responsibilities or transport issues which may impede health service access, and demonstrations of lack of person-centred care through labelling an individual as being non-compliant rather than seeking to understand the reasons behind them either choosing to be non-compliant or struggling to comply with suggested treatments, which may be related to many bio-psycho-socio-cultural factors.

Language barriers may be minimised by use of professional interpreters (including Translating and Interpreting Services [TIS] and Auslan interpreters). There should be consideration of the potential impact of communication difficulties on capacity to provide informed consent. When using professional interpreters, a number of factors need to be considered (outlined in CS1.1.1.5b). Multilingual patient resources may include use of culturally appropriate pictures and diagrams, health promotion posters in languages common in the local community, written information and reliable online resources, etc.[1]

Other barriers to communication may include:

- sensory impairment (acute or chronic hearing and/or visual or neurological impairment)
- chronic cognitive impairment
- acute medical conditions and injuries which may impair a conscious state related to head injury, hypoxia, cerebrovascular event, hypotension secondary to blood loss, delirium secondary to substance use, metabolic condition (eg ketoacidosis), renal or hepatic failure
- perceptual disturbance related to mental illness (eg acute psychosis)
- changed or challenging behaviours in individuals with intellectual disability or cognitive impairment, etc.

For individuals with sensory or chronic cognitive impairments, barriers can be managed by a combination of strategies such as respectfully asking individuals and/or carers about communication preferences, styles and techniques, using visual cues, written and pictorial materials, assistive technology and using 'check back' strategies to ensure that you are communicating effectively. Acknowledgement and minimisation of the impacts of clinic environmental factors on effectiveness of communication (eg interruptions, background noise) with individuals with sensory and/or cognitive impairment is important wherever possible.

It is also important to consider capacity to accommodate individuals who require gender-concordant care, skills to negotiate time alone with children and adolescents presenting with an adult guardian, (eg to discuss sexual health issues such as flagging a need for contraception), understanding of sexual consent, and ability to recognise unwanted sexual experiences.

Conditions to which stigma is attached (which may be related to sociocultural context) with consequent reticence to disclose, such as mental health or other sensitive issues (eg intimate partner or family violence, sexual assault, female genital mutilation, sexuality and gender issues, ie gender dysphoria), need to be handled sensitively and empathically. Patients are more likely to disclose sensitive or intimate issues when they have established trust in their therapeutic relationship. GPs need to have the capacity to recognise cues from their patients and ensure that they approach concerns about these experiences sensitively (refer to CS1.1.2.3).

Patients who present in an emotionally charged state may impact the effectiveness of communication. De-escalation skills are important to learn to improve confidence in managing such individuals (refer to CS1.1.1.5a).

Use of technology during consultations can act as a barrier to communication. Computerised medical software is commonly used and GPs need to be mindful about using good communication skills to ensure that the computer does not hold the focus of the consultation. As a balance to this, comprehensive and well-structured clinical notes are important for continuity of care and communication with other health professionals.

Useful resource

- Victorian Refugee Health Network. Promoting Refugee Health: A guide for doctors, nurses and other health care providers caring for people of refugee backgrounds. 3rd edn. Melbourne: Victorian Foundation for Survivors of Torture, 2012, http://refugeehealthnetwork.org.au/learn/guides

CS1.1.1.3b *Strategies to explore and integrate sociocultural context into consultations* – may include routine incorporation of cultural assessment into consultations (refer to CS1.1.1.3a), and a focus on cultural safety and development of cultural competence combined with awareness and management of an individual's cultural bias and cultural lens (refer to CS1.1.1.2c).

CS1.1.1.4b Consultation where effective use of empathy and sensitivity could improve outcomes – includes consultations where the GP has delivered patient-centred care through efforts to see things from the perspective of the patient, validation of that perspective, and utilising techniques such as active listening, reflection and summarising, asking questions to clarify, paying close attention to verbal and non-verbal cues, effective use of silence, etc. Patients experiencing chronic pain is an example of a common clinical situation where effective use of empathy is paramount – GPs who acknowledge that perceptions of pain are individual and often inherently linked with social, cultural, spiritual and psychological factors and comorbidities, and who sensitively incorporate relevant factors into management plans and communicate non-judgementally, will typically optimise outcomes for their patients.

Useful resource

- Warnecke E. The art of communication. Aust Fam Physician 2014;43(3):156–58, www.racgp.org.au/afp/2014/march/art-of-communication

CS1.1.1.5b *Professional interpreter services* – includes consultations with patients who speak no or limited English, or who may appear fluent but are more comfortable with their primary language when discussing complex health issues. It is important for GPs to recognise that language difficulties can negatively impact upon the care received by those from a culturally and linguistically diverse background. While an interpreter can assist in bridging the language gap, the cultural meaning embedded within language adds further complexity to cross-cultural consultations. 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. Linguistic difference can also reduce access to health education materials and impacts patients' knowledge about available health services.

Australian GPs are fortunate to have access to an Australian Government funded interpreter service (the Translating Interpreting Service Doctors Priority Line). Practices need to obtain a TIS client code to enable access by staff at the clinic. Effective use of professional phone or onsite interpreters is of paramount importance and is therefore a vital skill to learn. This service is free to the medical practice and the patient. It should be noted that general practice clinic staff, pharmacists and specialists in private practice also have access to free interpreting via TIS.

It can be argued that failure to use a professional interpreter in consultations with people from linguistically diverse backgrounds may be considered to be a breach in duty of care in many cases. Given the importance of effective communication in healthcare, interpreter use is an important risk management strategy. There are significant ethical concerns about using untrained individuals to interpret (such as family or friend), including the fact that there is no certainty of the accuracy of the information being conveyed, concerns about confidentiality and imposing unreasonable responsibility and stress on these individuals, particularly children and youth.

Key points to consider when using professional interpreters include:

- Use promotional material, which is readily visible in the waiting room, to make patients aware that the clinic uses onsite or telephone interpreters when needed.
- Early identification of the need for an interpreter, including noting this in the individual's clinical file, in order to enable an interpreter to be booked and an appropriate length of time for the consultation. Be aware that individuals may have preferences regarding preferred language, gender, ethnicity and, for individuals from small communities, even the location of the interpreter (interstate professionals may be preferred).
- Be clear on the language required. For example there are many variations/accents/dialects of Arabic, including Egyptian, Sudanese, Iraqi, Syrian, and more. This needs to be clear when booking an interpreter; however, the preferred dialect may not always be available.
- Be aware of whether the patient demonstrates signs of discomfort or suspicion regarding the interpreter, and address any problems as required (this can occur in the case of individuals who, for example, have migrated from areas of conflict where professionals may have participated in torture or informed on individuals to the government or armed forces).
- Inform patients that confidentiality is implicit in the role of interpreters.
- Discuss the process of the consultation with the interpreter and the patient in order to ensure each person is aware that they can clarify anything that does not make sense during the consultation.

- Speak to and (if culturally appropriate) maintain eye contact with the patient rather than the interpreter. Use the second person, eg 'Do you … ', not 'Does he/she …'
- Speak in short, readily interpretable segments and avoid medical jargon. Do not speak to the interpreter while excluding the patient; everything said in the consultation should be interpreted (this also applies to what the patient says).

Useful resources

- Victorian Refugee Health Network. Caring for refugee patients in general practice: A desktop guide. 4th edn. Melbourne: Victorian Foundation for Survivors of Torture, 2012, http://refugeehealthnetwork.org.au/?s=desktop+guide&silverghyll_tpicker=s=desktop+guide
- Huang Y, Phillips C. Telephone interpreters in general practice. Bridging the barriers to their use. Aust Fam Physician 2009;38(6):443–46.
- Victorian Refugee Health Network. Promoting Refugee Health: A guide for doctors, nurses and other health care providers caring for people of refugee backgrounds. 3rd edn. Melbourne: Victorian Foundation for Survivors of Torture, 2012, http://refugeehealthnetwork.org.au/learn/guides

C1.1.1.2c *Cultural competence* – may be viewed as a continuum and defined as the development of awareness and respect for differences in social structure and culture, and acknowledgement of the impacts of these on health and wellness beliefs and ability to engage with Australian health services. Culturally competent GPs have the ability to manage these differences respectfully.

Cultural competence has been defined as:

> 'A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated patterns of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs'.[1]

Skills in cultural competence may be attained through routine use of cultural assessments (refer to CS1.1.1.3a) and ongoing acknowledgement and management of a professional's own cultural bias and cultural lens.

Cultural safety is an important part of the spectrum of cultural competency. The emphasis for cultural safety is on reflective practice and professional empathy rather than awareness of culturally specific beliefs or practices. Cultural safety involves the development of awareness of power imbalance in therapeutic relationships which can negatively impact quality of care and development of strategies to minimise this.[2]

The 'cultural lens' refers to the GP's own unique personal worldview influenced by the cultures that nurtured them. This 'lens' may influence the way a health professional judges and makes 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 and thus it is important for health professionals to factor this into developing a collaborative therapeutic relationship. Cultural bias may be defined as interpreting and judging phenomena by standards inherent to one's own culture which in healthcare can contribute to misunderstandings impacting diagnosis and consequent management, power imbalances in the doctor–patient relationship, as well as bring up issues of class in some cultures.

Useful resources

- Kleinman A, Benson P.Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Medicine 2006;3(10):1673–76.
- Klein HA. Cognition in natural settings: The cultural lens model. Cultural Ergonomics: Advances in Human Performance and Cognitive Engineering Research, Vol 4. Emerald Group Publishing Ltd, 2004; p 249–80.
- NACCHO Cultural Safety Training Standards: A background paper, www.naccho.org.au/download/cultural_safety/CSTStandardsBackgroundPaper.pdf

CS1.1.1.4c *Practice processes to improve the quality of communication for patients in the practice* – may include ensuring patients are aware that feedback is welcomed (this can occur through provision of practice information brochures or posters) and that contact details of the state or territory provider of oversight of health service delivery (ie health services commissioner or ombudsman) are displayed in a prominent position. It is also important to consider systems that ensure appropriate feedback and support is provided if complaints are raised about communication skills and that follow-up occurs to ensure improvements have been made as a result, guaranteeing that systems are in place to routinely organise interpreters for patients who require this service, multilingual patient information is provided to the relevant patient population, and appropriate information is available according to the various levels of health literacy of patients at the practice.

CS1.1.2.1a *Factors to consider when breaking bad news* – may include informing a patient or family member that they or a relative has a condition which may seriously impact their future. This often is thought to relate to informing a patient about a potentially terminal diagnosis; however, whether a diagnosis is perceived as being 'bad news' is most impacted by the context and expectations of the patient. Such diagnoses may include cancer, type 1 diabetes, psoriasis, alopecia, multiple sclerosis, dementia, a significant injury which may impact a sportsperson's ability to compete long-term, and informing a pregnant couple that their baby has a chromosomal abnormality or congenital abnormality, etc.

It can be difficult to estimate the impact the bad news will have on the recipient until the GP has determined the expectations that the individual has of the consultation and their understanding of the possible diagnoses and/or outcomes. There are a number of different frameworks to assist with developing skills in this area, including the widely used SPIKES (Setting, Perception, Invitation/Information, Knowledge, Empathy, Summarise/Strategise) model,[3] which is explained in detail at CS1.1.1.4b.

CS1.1.2.2a *Effectively manage patients who are distressed or agitated* – may include individuals who:

- are emotionally distressed after receiving bad news
- have unmet expectations during or after a consultation (eg drug-seeking patients whose requests have been declined)
- are agitated due to experiencing delirium or psychosis related to medical or psychiatric conditions
- are frustrated because of long wait times
- are substance-affected.

There is a broad range of presentations of distress and/or agitation and, at the more extreme end, this can result in threats to the wellbeing of the GP, practice staff and members of the public in the vicinity. Early identification cues of distress or agitation can include aggressive body language, expressing dissatisfaction in the waiting room, appearing to be responding to auditory or visual hallucinations, smelling of alcohol, or demonstrating signs of being substance-affected, etc.

Attempting to understand the reason for the agitation or distress can be important in managing such individuals; however, a tentative diagnosis is often all that is possible in emergency situations if there is no prior knowledge or experience with the patient. Ensuring personal safety and the safety of others in the vicinity, including practice staff and other patients, is of paramount importance. This can be improved by physical and experiential practice structures such as the availability of duress alarms, avoidance of extremes in sound, wall colour and temperature to minimise sensory overstimulation, adequate exits to ensure that staff have access to safe exits if others are blocked, and the availability of regular staff training in managing behavioural emergencies and identifying early signs of agitation.

De-escalation techniques are important skills to develop. These may include paying attention to respect for personal space, avoidance of provocative language or physicality, establishing clear and concise verbal communication, identifying wants and feelings of the individual, trying to avoid judgement and clearly stating whether you agree or disagree with them, setting clear and non-threatening limits, providing individuals with choices and optimism, and ensuring all staff members have access to debriefing following the incident.

Useful resources

- Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med 2012;13(1):17–25, www.ncbi.nlm.nih.gov/pmc/articles/PMC3298202
- Fishkind AB. Calming agitation with words not drugs: 10 commandments for safety. Current Psych 2002;1(4), www.currentpsychiatry.com/index.php?id=22661&tx_ttnews[tt_news]=181234

CS1.1.2.3a *Patients who may be experiencing consequences of trauma* – may include patients who have had a history of exposure to family violence in childhood and may then develop complex post-traumatic stress disorder (PTSD) (formerly known as borderline personality disorder), and women who have been exposed to intimate partner violence and may present with anxiety disorders or substance abuse disorders. These histories are often hidden and the signs of possible previous exposure therefore need to be keenly sought out.

Individuals who have migrated to Australia under a humanitarian program or as asylum seekers often have histories of exposure to torture and trauma, which can be compounded by issues following their arrival in Australia (eg time in detention).

Military and emergency service personnel are commonly exposed to trauma which can present soon after a particular event or many years later. PTSD is a common consequence of such circumstances and needs to be identified and managed to optimise outcomes. Vicarious trauma is another possibility to be considered in individuals who provide support and/or counselling to groups who have experienced traumatic events. Peer support through regular debriefing and/or professional counselling can be beneficial for these people.

Useful resources

- The Royal Australian College of General Practitioners. Abuse and violence: Working with our patients in general practice (White book). Melbourne: RACGP, 2014, www.racgp.org.au/your-practice/guidelines/whitebook
- Adults Surviving Child Abuse. Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. ASCA, 2012, www.asca.org.au/Portals/2/Practice%20Guidelines/ASCA%20Guidelines%202014_WEB_Final.pdf

CS1.1.2.1.b *Strategies to assist in breaking bad news* (also refer to CS1.1.1.4a) – may include:

- ensuring that you have adequate time available to ensure that the patient does not feel rushed and is able to express what they need to, and to enable the GP to respond to the patient's emotional reactions
- involving the patient in decision-making
- dealing with the stress created by the patient's expectations for cure
- the involvement of multiple family members
- the dilemma of how to give hope when the situation is bleak.

The complexity of the interaction can sometimes create serious miscommunications, such as patient misunderstanding about the prognosis of the illness or purpose of care. Poor communication may also thwart the goal of understanding patient expectations of treatment or involving the patient in treatment planning. The SPIKES model is a useful framework to assist in delivering bad news:

- **S**et up interview – sit down, ensure privacy, minimise interruptions, involve significant others, ensure the patient has a safe way to get home.
- **P**erception assessment – 'What have you been told so far?'
- Obtaining the patient's **I**nvitation to proceed; **I**nvite patient to determine how consultation will go – 'How would you like me to give you this information?'
- Giving **K**nowledge and information – 'I'm so sorry, I'm afraid I have bad news'.
- **E**motional assessment and **E**mpathy – sit with the patient, provide them time to express what they need to, use appropriate physical contact.
- **S**trategy and **S**ummary – ask the patient whether they are ready to talk about a plan from this point.[3]

CS1.1.2.2b *Assess and effectively manage an agitated patient or family member* – may include the need to assess the person in order to evaluate the cause of their agitation, including emotional distress related to a bad prognosis, anger at perceptions of being treated unfairly or inappropriately (refer to CS1.3.4) , having unmet expectations regarding treatment (particularly relevant to drug-seeking patients), experiencing a delirium related to substance use or a health condition such as a metabolic imbalance, a head injury or a psychotic disorder, etc. Effective management involves optimising safety of the GP, practice staff and members of the public in the vicinity (including family members and carers of the agitated individual).

CS1.1.2.3b *Prognosis and end-of-life decisions* – refers to ensuring that the patient and/or carer understands the likely outcome of the diagnosed condition with consequent impacts on quality of life indicators, and requirements for care and management plans. This is relevant for a broad range of conditions and, as per CS1.1.1.4a, can include:

- sports injuries for athletes
- chronic dermatological conditions with cosmetic consequences and subsequent impacts on self-image and self-esteem
- chronic diseases requiring intervention and ongoing management (eg chronic obstructive pulmonary disease [COPD], diabetes, congestive cardiac failure, epilepsy)
- diseases with a course that is likely to involve ongoing deterioration, such as primary progressive multiple sclerosis or amyotrophic lateral sclerosis).

It is often the role of the GP to facilitate advanced care planning and directives in patients nearing the end of their lives. This will enable future health and wellbeing care which is person-centred and based on the principles of self-determination, dignity and the avoidance of suffering. The purpose is to incorporate the individual's values, beliefs and preferences to guide decision making if and when the individual is unable to communicate their wishes.

Useful resource

- Bird S. Advance care planning. Aust Fam Physician 2014;43(8):526–28, www.racgp.org.au/afp/2014/august/advance-care-planning

CS1.1.2.4b *Consequences of trauma* – may include individuals who have been traumatised as a result of exposure to a single incident or cumulative exposure, and those experiencing an acute stress reaction or more chronic effects (PTSD and complex PTSD). Individuals who have experienced the effects of trauma are common in general practice (65% of men and 50% of women are exposed to a potentially traumatic event in their lifetime[4]) and are often unrecognised. It is thus important for GPs to recognise the many ways in which trauma can present. Examples of traumatic exposures include:

- involvement in war
- experiencing natural disasters
- survivors of torture
- survivors of childhood emotional, physical or sexual abuse (may present as complex PTSD in adults, previously known as borderline personality disorder)
- adult survivors of family violence
- survivors of violent crime or accidents
- individuals who have experienced medical trauma, which can result from medical procedures that are considered successful but experienced as traumatic by the individual (eg complicated labour, involuntary admission to a psychiatric unit).[5]

The experience of trauma stems from the overwhelming of coping capacity in light of precipitating event(s) and, if not resolved, has a range of negative impacts on physical and psychological health. The consequences of trauma can impact on how individuals engage with health professionals and services, and their ability to undertake medical care such as routine screening (eg Pap smears in women who have experienced childhood or adult sexual abuse).

Individuals who have experienced trauma can appear with a wide variety of presentations, including eating disorders, substance-use issues, anxiety, self-harming and undifferentiated illness (such as complex pain syndromes), etc. Not all individuals with these health issues have experienced trauma; however, it may be useful for GPs to assume that every patient in practice may have been exposed to a form of trauma in the past. GPs need to communicate sensitively and empathically when caring for individuals who may have experienced trauma, and utilise communication techniques such as active listening and validation of patient experience.

Assessing safety levels for individuals who are in situations in which they are continuing to experience trauma is imperative, by utilising techniques such as 'psychological first aid' (which may include monitoring of mental state, provision of emotional support, education and encouragement of active use of social support and self-care strategies), consideration of trauma-focused cognitive behavioural therapy (CBT) or dialectical behaviour therapy (DBT) for complex PTSD and eye movement desensitisation and reprocessing (EMDR), etc.

Useful resources

- Adults Surviving Child Abuse. Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. ASCA, 2012, www.asca.org.au/Portals/2/Practice%20Guidelines/ASCA%20Guidelines%202014_WEB_Final.pdf
- Centers for Disease Control and Prevention. Adverse Childhood Experiences Study 1997, www.cdc.gov/violenceprevention/acestudy
- Forbes D, Creamer MC, Phelps AJ, et al. Treating adults with acute stress disorder and post-traumatic stress disorder in general practice: a clinical update. Med J Aust 2007;187(2):120–23.

CS1.1.2.1c *Optimise safety of staff* – may include:

- regular training in identification of early signs which may lead to aggressive behaviour (eg individuals who are noticeably affected by substances such as alcohol or methamphetamine)
- identifying individuals in the waiting room who are pacing or visibly irritable
- training in management of aggressive individuals, including simple de-escalation techniques and confidence to implement safety net strategies if these are not effective
- ensuring there is an escape route if confronted
- ensuring there are at least two staff members in the facility at all times
- ensuring there are duress alarms in place and that emergency service contact numbers are visible.

CS1.1.3 *Family, carers and others* – may include any individual who participates in a care role for a patient, including staff in residential aged care facilities and interpreters.

CS1.1.3.3a *Ethical strategies to manage confidentiality and to obtain informed consent* – acknowledges that confidentiality is central to an effective therapeutic relationship and that assessment of capacity to provide consent is an integral part of ensuring ethical practice (refer to CS5.2.1 and CS5.2.2). Strategies may include ensuring that GPs have specific informed consent from their patients to discuss particular health issues with family and/or carers, advising family members of the importance of confidentiality, and not providing confidential patient information without consent. Complexities may arise in regards to individuals where their capacity to provide consent is not clear to the GP and/or the family and/or carers. Examples of this may include adolescents who may have a legal right to provide informed consent to medical procedures/management without parental consent according to the GP but the parents do not agree, or individuals with cognitive impairment who have a legal medical power of attorney or guardian but disagree with a decision made by this person.

CS1.1.3.3b *Management plan discussions* – may include discussions regarding end-of-life care, eg palliation, in regards to advanced care planning in collaboration with patients, patients with cognitive decline or intellectual disability, etc.

CS1.1.3.4b *Impacts of burden of care* – may include:

- examples of identifying signs of stress in carers (particularly individuals with chronic mental health issues, older patients with intensive needs, individuals with sensory, physical or intellectual disabilities, individuals who are receiving palliation for end-of-life care, etc)

- discussing and organising respite as required
- identifying grief reactions, distress and fatigue
- identifying signs that carers are not coping with their workload and providing support and advice regarding management
- assisting with bereavement, etc.

CS1.1.4 ***Complaints and concerns*** – may include complaints about yourself, a colleague within your clinic or a practitioner to whom you have referred a patient. Complaints may be made by patients, family members, health professionals or other staff within or external to the clinic. Broad categories of complaints include patient perceptions of poor communication and interpersonal skills, inappropriate or inadequate treatment, inadequate quality of care such as incorrect or missed diagnoses, inappropriate referrals for diagnostic or management procedures, issues raised by family members or carers regarding quality of care provided and concerns about waiting times, etc. Effective management strategies may include those outlined in 1.1.4.1b.

Useful resource

- Walton M, Smith-Merry J, Healy J, McDonald F. Health complaint commissions in Australia: Time for a national approach to data collection. Australian Review of Public Affairs 2012;11(1):1–18, www.australianreview.net/journal/v11/n1/walton_etal.pdf

CS1.1.4.1b ***Effective problem-solving approaches to address patient complaints*** – may include:

- acknowledging and, if appropriate, validating the complaint or concern and its impact on the individual (issues that may appear trivial to you may be emotionally distressing for the patient)
- offering an apology to the complainant if appropriate, while recognising that this is not admission of guilt (eg 'I am sorry that this has happened' or 'I am sorry that you are upset about this')
- developing an understanding of the needs of the person making the complaint and addressing these in a logical and clear fashion
- using an empathic approach to relate to the perspective of the individual
- ensuring that you do not ignore complaints and make a concerted effort to manage complaints made about you. This may consist of acknowledging the complaint in person or over the phone, and either dealing with it at the time or discussing the plan as to how this is going to be addressed with the individual.
- organising a follow-up time to discuss the outcome of the complaint investigation.

It is important to try to maintain the therapeutic relationship; however, if this is not possible ensure that you hand over care to another health professional. It may also be important to contact your medical defence organisation to notify them of the complaint. Managing complaints can be extremely stressful, so ensure that you are looking after yourself and that you have support and space to debrief if required. When the complaint has been resolved, ensure that you reflect back on what has occurred and review practices and processes to minimise risk of this happening again in the future.

CS1.1.4.4b ***External resources*** – may include providing patients with contact details of the state-based or territory-based complaint management mechanisms, such as the health services commissioner, health ombudsman or Australian Health Practitioner Regulation Agency (AHPRA).

CS1.1.4.4c ***Practice structures for managing complaints effectively*** – may include:

- designation of roles within the practice for complaint management (ie a senior administrative staff member to manage complaints related to reception staff and a senior clinical staff member to manage complaints related to clinical staff or management)
- ensuring that patients are aware of mechanisms available for managing complaints
- ensuring that review strategies are in place when complaints are made

- improving practice systems and processes to minimise future risk
- ensuring that staff are adequately supported during the usually stressful complaint process, etc.

CS1.2 ***Effective health education*** – encapsulates the provision of accurate and timely, evidence-based, quality health information and decision aids to patients by means most appropriate to their individual context (taking into account sociocultural factors and level of health literacy). Mechanisms may include through socioculturally appropriate verbal and written information on diagnoses and/or management options, including health promotion activities via electronic or paper-based resources to educate, empower and assist in developing rapport with patients. The use of psychological techniques such as motivational counselling, CBT and/or mindfulness to encourage and sustain behavioural change to optimise health are also important educational tools to address barriers to optimising care and maintaining compliance with treatment. Empowerment through education and provision of ongoing support to maintain self-care strategies to optimise health outcomes is another important aspect of effective health education.

Health education provided by GPs covers a broad range of issues to suit the diverse range of patients and health conditions seen in general practice, eg information on reproductive health (such as safe sex), optimising fertility and options for effective contraception, information on prevention regarding healthy lifestyle, nutrition and exercise, smoking cessation, stress minimisation, sexuality, mental health awareness, etc.

CS1.2 ***Promote health and wellbeing*** – the World Health Organization (WHO) defines health as 'A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[6]

Health may be promoted in general practice through provision of advice that caters to the bio-psychosocial needs of the individual. This may include ways to prevent illness through:

- optimising nutrition and exercise
- minimising and managing stress
- education and promotion of early return-to-work after work-related injuries or illness
- provision of education on safe sex and other strategies to maintain or improve sexual and reproductive health (eg effective contraception, education around consent and identification of individuals at risk of intimate partner violence)
- identification of need for harm minimisation strategies regarding substance use
- identification of signs of substance dependence and addiction (eg alcohol, cigarettes, marijuana, methamphetamine, gambling, etc)
- identification of opportunities to prevent injury and disease in at-risk individuals (eg due to participation in certain sports, hobbies or occupations)
- identifying and managing safety risks for older patients, etc.

CS1.2 ***To empower patients*** – describes the process of supporting and increasing the capacity of individuals or groups to make informed choices and to transform those choices into desired actions and health and wellbeing outcomes. Shared decision making and effective provision of health education appropriate to the individual's level of health literacy and needs are important factors to assist in achieving this. An example of empowerment may include providing information which enables individuals to self-care and to recognise when they need to seek advice.

CS1.2.1.1a ***Identify patients who would benefit from health promotion education*** – highlights the need to identify individuals or groups who are at risk of disease or injury and thus require education and/or intervention to minimise this risk through provision of preventive care. It would be difficult to find a patient attending a general practice who wouldn't benefit from targeted health promotion education. Some examples include:

- older patients – may be at risk of falls, so enrolment in a falls prevention program, as well as education of the individual and family members about the importance of enhancing safety structures at home (eg avoiding clutter on the floor, use of safety rails) may be useful

- women or couples who are contemplating conceiving or are in the early stages of pregnancy – may need information regarding reducing risk factors for adverse pregnancy outcomes, such as smoking, alcohol intake, illicit substance use, and consideration of opportunistic vaccination and screening for those at risk of inherited conditions such as thalassaemia
- gay, lesbian, bisexual, transgender or intersex individuals – may require non-judgemental support in regards to gender identify or sexual identity issues, may benefit from education about maintaining sexual health through risk reduction and/or regular access to screening, and adolescents may benefit from education about safe sex, support and normalisation of sexual and gender identity beliefs
- patients recognised to be overweight – may benefit from an empathic provision of support and advice around nutrition and exercise
- new parents – may benefit from opportunistic provision of advice on vaccination of relatives of new babies
- individuals at risk of genetically inherited conditions – may consider genetic testing, screening or review of themselves or family members as appropriate. Inherited conditions may include hereditary nonpolyposis colorectal cancer (HNPCC), breast cancer if two or more family members diagnosed under 50 years or one male family member has bilateral disease diagnosed, haemochromatosis, hypertrophic obstructive cardiomyopathy (HOCM) and coeliac disease.

CS1.2.1.1b *Opportunities to effect positive change through health education and promotion* – the WHO defines effective health promotion as 'the process of enabling people to increase control over and improve their health'. The principles and efforts of health promotion are utilised in social systems, diseases, risk factors and population groups and may occur through provision of quality information and education which is appropriate to the individual and to their sociocultural context.[7]

GPs are often in a prime position to offer preventive health advice and thus health promotion. Examples may include:

- provision of advice on lifestyle modification in regards to maintaining a nutritious, balanced diet, healthy exercise regime, smoking cessation, minimising alcohol intake and stress management
- timely discussions around return-to-work, including the health benefits of work, early in the experience of a physical or mental illness and framing expectations regarding early return-to-work and effective rehabilitation to reduce risk of chronicity, recurrence and/or re-injury
- effective pre-conception and antenatal counselling regarding genetic screening of women and couples at risk of inherited conditions through family history of inherited conditions or other risk factors for genetic abnormalities, such as parental age. Effective counselling includes discussion of risks such as financial costs and potential benefits of screening
- provision of information in travel medicine consultations to reduce risk of injury or illness during travel
- harm minimisation discussions with patients with substance addictions.

The use of electronic technologies such as videoconferencing and mobile phone health applications to communicate information can be valuable in effecting positive changes which optimise health outcomes.

CS1.2.1.2a *Barriers to patients implementing important health promotion and self-care activities* – may include individuals who:

- are struggling to manage social stressors and work commitments and who are unable to make time for their own health
- have a severe health condition which impacts their ability to recognise other health conditions or access care
- have language or cultural barriers impacting access to information and care (eg refugees or asylum seekers)
- have problems with addiction or substance dependence (eg dependent on alcohol, marijuana, methamphetamine, gambling, etc) and are unable to prioritise their own health due to the consequences of their addictions

- are carers for people with high-level needs (eg cognitive and/or physical disabilities, terminal conditions, etc)
- are experiencing severe mental health issues which impact their ability to prioritise other health needs (eg psychotic conditions, complex PTSD, severe depression, etc).

CS1.2.1.3a *Opportunistic life-stage counselling* – describes the important role that GPs play in recognising when an individual may benefit from the provision of information to improve their health and wellbeing, when they may have presented with an unrelated issue. This strategy is often key to the provision of preventive healthcare. Examples may include counselling:

- parents of young children regarding developmental screening
- women in the child-bearing years regarding pre-conception care and screening
- adolescents regarding safe sex, mental health awareness and gender or sexual identity issues
- middle-aged women regarding common issues experienced at this time related to menopause
- older individuals regarding falls prevention, consideration of advanced care plans, etc.

CS1.2.1.2b *Opportunistic effective counselling about normal life stages* – refers to the importance of developing skills to identify and explain normal physiology and psychology, and the pathological deviations from this. Examples include recognition of:

- functional and dysfunctional personality traits, and consequent behaviours and impacts on health
- normal and complicated grief and stress reactions
- the role of hormonal change around menarche, pregnancy, fertility and menopause on physical and psychological functioning and sexuality
- prostatic hypertrophy, and the impacts of hormonal changes on physical and psychological functioning and sexuality throughout the lifecycle of men
- methods to optimise fertility using lifestyle modification and education regarding fertility awareness-based methods (FABM) of contraception, such as the Billings ovulation method.

CS1.2.1.3b *Address barriers to patients implementing health promotion and self-care activities* – involves recognising how behaviour, sociocultural values and attitudes impact health, and the utilisation of strategies to address these. Examples include:

- harnessing specific individual traits and behaviours to promote greater self-care and access to healthcare (eg using individually appropriate analogies for some male patients, such as prioritising regular health checks, similarly to regular car services)
- utilising technology such as smart phone apps, and web-based or paper-based resources to track – and thus improve – insight into symptoms or behaviours to motivate change (eg for weight loss, diabetes management, etc)
- organising regular review and follow-up for individuals who have low levels of motivation and/or insight into health risks in order to provide support and education to assist them in moving through the 'stages of change' more efficiently.

CS1.2.1.4b *Gaps in health education resources* – relates to the need to identify that the available health education resources do not meet the needs of the local community. This includes recognising the need for multilingual health education resources for patients from CALD backgrounds, audio tools for patients who are vision-impaired, diverse and appropriate resources for patients who identify as gay, lesbian, bisexual or transgender.

CS1.2.1.5b *Appropriate strategies to motivate* – may include identifying the stage of the change model[8] at which an individual is currently sitting, assessing their level of health literacy, gaining insight into their health risks, and acknowledging any sociocultural factors which may be promoters or barriers to sustaining healthy behaviour change. Provision of education about risks to the individual of not changing behaviour is an important part of this process.

The SNAP (smoking, nutrition, alcohol and physical activity) model[9] can be a useful framework to identify unhealthy behaviours which, when combined with the development of an effective therapeutic relationship with regular review, follow-up and/or referral, can assist in establishing and maintaining positive change. Other strategies to consider include education, provision of web-based or paper based-resources and tools (such as sleep diaries, activity logs or food diaries), and use of motivational interviewing, CBT, interpersonal skills training, anger management, structured problem solving and family therapy.

CS1.2.1.2c *Different health belief systems* – it is broadly accepted that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. Personal perception is influenced by a broad range of sociocultural factors, particularly education and health literacy, previous experiences, cultural factors, religion, peer group and family beliefs. The health belief model is made up of four perceptual constructs which can be used individually, or in combination, to explain health behaviour. These perceptual constructs are: perceived seriousness of disease, perceived susceptibility to disease, perceived benefits of changing behaviour at reducing risk to disease, and barriers to changes in behaviour.[10]

Other important modifying influences which impact health behaviour include cues to action or motivating factors (eg illness in a family member or friend, media reports, health warnings) and sense of self-efficacy (ie a belief in one's own ability to do something). Beliefs of Aboriginal and Torres Strait Islander peoples, traditional Chinese medicine, the Catholic church and contraception, Jehovah's witnesses and blood transfusions are examples of well-established health belief systems which need to be acknowledged and understood in consultations, as they vary from the Western biomedical model and thus may impact whether individuals are likely to engage with and accept health services.

CS1.2.1.2c *Biomedical model* – describes a conceptual framework for objectively explaining disease that includes only biological factors such as pathology, biochemistry and physiology, and does not take social, psychological or individual subjective influences into account.

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Domain 2. Applied professional knowledge and skills

'Cure sometimes, treat often and comfort always' – Hippocrates.

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
CS2.1 GPs provide the primary contact for *holistic and patient-centred care*	**CS2.1.1** The conduct of the consultation is appropriate to the *needs of the patient* and the sociocultural context	**CS2.1.1.1a** Define holistic and patient-centred care	**CS2.1.1.1b** Incorporate patient treatment and management preferences when appropriate	**CS2.1.1.1c** Evaluate the provision of holistic and patient-centred care in the practice
		CS2.1.1.2a Utilise strategies to identify the *needs, expectations and sociocultural context* of patients	**CS2.1.1.2b** Incorporate the impact of diagnoses and management on other family members and/or carers into care planning	**CS2.1.1.2c** Implement strategies to mentor and support colleagues to provide holistic and patient-centred care
		CS2.1.1.3a Explain the benefits and difficulties of individualising consultations to incorporate needs, expectations and sociocultural context	**CS2.1.1.3b** Identify and manage situations where there are *challenges to delivering a patient-centred approach*	
		CS2.1.1.4a Describe strategies to identify and *manage unreasonable patient or carer expectations*	**CS2.1.1.4b** Implement effective strategies to *manage patient needs and expectations that cannot be met*	
	CS2.1.2 *Continuity of care* promotes quality and safety	**CS2.1.2.1a** Identify the key *factors that support and contribute to quality continuity of care*	**CS2.1.2.1b** Identify and manage factors that are barriers to, and those that promote, continuity of care	**CS2.1.2.1c** Identify consequences of missed opportunities for continuity of care and review practice structures to reduce future risk and to optimise care
		CS2.1.2.2a Outline the risks of not providing adequate continuity of care		**CS2.1.2.2c** Implement quality improvements that support continuity of care for patients
	CS2.1.3 *Comprehensive and holistic management plans* are developed collaboratively	**CS2.1.3.1a** Utilise and contribute to *event and shared health summaries*	**CS2.1.3.1b** Formulate a *collaborative approach to management plan development*	**CS2.1.3.1c** Develop systems to support effective management planning to optimise outcomes
		CS2.1.3.2a Identify individuals who would benefit from having a management plan in place	**CS2.1.3.2b** Develop strategies to maintain management plans that are *relevant to patient needs*	
		CS2.1.3.3a Outline the key features of an *effective, holistic management plan*		

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
CS2.2 GPs diagnose and manage the full range of *health conditions* in a diverse range of patients *across the lifespan through a therapeutic relationship*	**CS2.2.1** A comprehensive, clearly documented *biopsychosocial history* is taken from the patient	**CS2.2.1.1a** Describe the key features of a comprehensive biopsychosocial history	**CS2.2.1.1b** *Identify priorities and negotiate an agenda* for the consultation	**CS2.2.1.1c** Appraise and revise as appropriate biopsychosocial history taking to maintain quality of care
		CS2.2.1.2a Demonstrate *effective history taking and documentation* using the biopsychosocial model	**CS2.2.1.2b** Identify and sensitively address *psychological factors contributing to or consequences of physical symptoms*	
		CS2.2.1.3a Identify the key signs to be determined on physical examination during history taking	**CS2.2.1.3b** Appropriately utilise and interpret *assessment tools* to optimise history taking	
		CS2.2.1.4a *Identify potential impacts of sociocultural factors on presentation, engagement and compliance*		
	CS2.2.2 *An appropriate and respectful physical examination* of the patient is undertaken	**CS2.2.2.1a** Obtain *informed consent prior to undertaking a physical examination*	**CS2.2.2.1b** Use *strategies that ensure patient comfort* when undertaking respectful physical examination	**CS2.1.2.1c** Identify and address any skill gaps for effective physical examination
		CS2.2.2.2a Demonstrate appropriate and respectful physical examination technique	**CS2.2.2.2b** Effectively utilise *appropriate clinical tools* to optimise examination	**CS2.1.2.2c** Support and mentor colleagues in maintaining physical examination skills
		CS2.2.2.3a Identify and manage situations where there may be *barriers to physical examination*	**CS2.2.2.3b** Effectively summarise key examination findings for the patient	**CS2.1.2.3c** Mentor colleagues in sensitive management of inconsistencies between physical examination findings and history
		CS2.2.2.4a *Acquire positive and relevant negative signs to assist with diagnosis*	**CS2.2.2.4b** Identify, *negotiate and manage barriers to effective physical examination* to avoid compromising quality of care	
		CS2.2.2.5a Identify situations where *physical examination findings are inconsistent with history*	**CS2.2.2.5b** Effectively manage situations where *the physical examination findings are not consistent with history* provided	

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
	CS2.2.3 *A significantly ill* patient is identified and managed appropriately	**CS2.2.3.1a** Outline the key symptoms and signs to *identify a significantly ill patient across the lifespan*	**CS2.2.3.1b** Establish a diagnosis and *manage clinical presentations of acute serious illness and trauma efficiently and appropriately*	**CS2.2.3.1c** Undertake regular reviews of emergency management skills to ensure relevance and currency is maintained
		CS2.2.3.2a Explain the *criteria used to determine when acute resuscitation should be instituted*	**CS2.2.3.2b** Evaluate *emergency management skills* to identify areas requiring improvement and support	**CS2.2.3.2c** Support and *debrief colleagues as required following management of a significantly ill patient*
		CS2.2.3.3a Devise an *efficient treatment plan to optimise outcomes*	**CS2.1.3.3b** Outline criteria for and *maintain competence in basic and advanced life support*	
		CS2.2.3.4a Demonstrate *contemporary practice of basic life support*		
	CS2.2.4 *A rational list of differential diagnoses* is formulated	**CS2.2.4.1a** Differentiate *variations of normal physiology and psychology from pathological* ones	**CS2.2.4.1b** Effectively *counsel patients regarding variations of normal physiology and management*	**CS2.2.4.1c** Review quality of documentation of differential diagnoses
		CS2.2.4.2a Describe the *principles and criteria used to develop differential diagnoses*	**CS2.2.4.2b** Routinely document and *stratify risk of differential diagnoses* when assessing patients	**CS2.2.4.2c** Assist colleagues in identification and management of non-accidental injury
		CS2.2.4.3a Formulate concise differential diagnoses for common presentations by integrating information gained from effective history taking and examination	**CS2.2.4.3b** Formulate, defend and prioritise differential diagnoses to assist with clinical decision making	
			CS2.2.4.4b Identify and manage *non-accidental injury*	
	CS2.2.5 Appropriate procedures are undertaken after receiving informed consent	**CS2.2.5.1a** Identify individuals who may benefit from procedural intervention	**CS2.2.5.1b** Choose the *appropriate procedure based on the patient's need and context*	**CS2.2.5.1c** Review procedural skills and undergo further training as appropriate to maintain quality care
		CS2.2.5.2a Outline the key features of *quality informed consent for procedures*	**CS2.2.5.2b** Perform and document *appropriate medical procedures and aftercare* with informed consent	**CS2.2.5.2c** Support and mentor colleagues in performing appropriate procedures

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
		CS2.2.5.3a Describe *factors that influence which procedures may be undertaken safely in general practice*	**CS2.2.5.3b** Identify procedural skill limitations and refer appropriately	
		CS.2.5.4a Undertake procedures under appropriate supervision		
	CS2.2.6 *Rational options for investigations* are offered	**CS2.2.6.1a** Identify individuals who require further investigation to obtain a diagnosis or to clarify a management plan	**CS2.2.6.1b** Outline and justify referrals for investigations in the individual's context	**CS2.2.6.1c** Review and compare *investigation referral patterns* with peers to ensure quality provision of care
		CS2.2.6.2a Outline the *factors to consider when choosing the most appropriate investigations*	**CS2.2.6.2b** Effectively communicate regarding the *limitations, risks and benefits* of proposed investigations to enable informed consent	
	CS2.2.7 The results of investigations are interpreted in the context of the patient	**CS2.2.7.1a** Identify *clinical situations where normal (or abnormal) results are not considered normal (or abnormal) for the individual*	**CS2.2.7.1b** Develop *strategies to ensure that results are reviewed and interpreted*	**CS2.2.7.1c** Assist colleagues in interpreting and communicating complex or difficult results
		CS2.2.7.2a *Effectively communicate relevant results, integrating the context of the individual*	**CS2.2.7.2b** Demonstrate effective communication of both normal and abnormal results to patients	**CS2.2.7.2c** Develop robust and efficient systems to ensure that results are interpreted and communicated to patients
	CS2.2.8 Diagnosis and management is evidence-based and relevant to the needs of the patient	**CS2.2.8.1a** Identify *approaches to communicating evidence effectively to patients*	**CS2.2.8.1b** Demonstrate *effective counselling* regarding management options	**CS2.2.8.1c** Validate treatment recommendations against quality evidence-based resources
		CS2.2.8.2a Routinely summarise holistic *treatment options* when seeing patients	**CS2.2.8.2b** *Formulate safe strategies to provide care for patients who decline evidence-based management options*	**CS2.2.8.2c** Implement or review processes to maintain currency of evidence-based knowledge to provide quality care
		CS2.2.8.2b Formulate safe strategies to provide care for patients who decline evidence-based management options	**CS2.2.8.3b** Identify and address modifiable *primary, secondary and tertiary prognostic factors* for common conditions	
	CS2.2.9 *Rational prescribing and medication monitoring* is undertaken	**CS2.2.9.1a** identify the *key factors to consider* when selecting the most appropriate medication	**CS2.2.9.1b** Identify and utilise *quality and unbiased resources* to assist in appropriate prescribing of treatments	**CS2.2.9.1c** Review and revise patterns of prescribing to improve quality and safety

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
		CS2.2.9.2a Identify *useful evidence-based guidelines to assist in prescribing* appropriately	**CS2.2.9.2b** Identify the *role of off-label prescribing and implement risk-minimisation strategies*	**CS2.2.9.2c** Review and address issues with practice policies regarding storage and use of medications
		CS2.2.9.3a Effectively counsel patients regarding *medication safety and compliance*	**CS2.2.9.3b** Utilise *robust strategies* to monitor and manage *medication side effects and risks of polypharmacy*	**CS2.2.9.3c** Maintain and disseminate *up-to-date prescribing knowledge* and strategies
		CS2.2.9.4a Outline *common prescription and over-the-counter drug interactions*	**CS2.2.9.4b** *Report medication side effects appropriately*	**CS2.2.9.4c** Meet patient needs through *specialised prescribing*
		CS2.2.9.5a Describe *principles of pharmacotherapy withdrawal*	**CS2.2.9.5b** Identify and effectively *address barriers to medication compliance*	
			CS2.2.9.6b Devise strategies to provide *quality care to patients who decline recommended medications*	
			CS2.2.9.7b Develop strategies to identify and manage *medication misuse and withdrawal*	
			CS2.2.9.8b Safely prescribe *restricted medications using appropriate permits*	
			CS2.2.9.9b Identify and manage any *conflicts of interest* in prescribed treatments	
	CS2.2.10 The uncertainty of ongoing *undifferentiated conditions* is managed	**CS2.2.10.1a** Outline *areas of risk in managing patients with undifferentiated conditions*	**CS2.2.10.1b** Develop *management plans that support the early identification of evolving conditions*	**CS2.2.10.1c** Evaluate how diagnostic uncertainty impacts referral and management practices in patients with undifferentiated conditions
		CS2.2.10.2a Evaluate the potential for delayed or incorrect diagnosis in cases of undifferentiated conditions	**CS2.2.10.2b** Identify and manage the *key mental health diagnoses that may present as, or compound, undifferentiated condition presentations*	**CS2.2.10.2c** Appraise management strategies of common undifferentiated conditions

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
			CS2.2.10.3b Identify and manage the *key sociocultural factors that may present as, or compound, undifferentiated condition presentations*	**CS2.2.10.3c** Outline *strategies and obstacles to implementing an evidence-based approach to management of common undifferentiated conditions*
			CS2.2.10.4b *Assess impacts of diagnostic uncertainty on clinical decision making, balancing benefits against risks*	
CS2.3 GPs are informed and innovative	**CS2.3.1** Quality *evidence-based resources* are critically analysed and utilised	**CS2.3.1.1a** Define and critique *evidence-based medicine* as an approach to care	**CS2.3.1.1b** Critically analyse research relevant to common clinical presentations	**CS.2.3.1.1c** Review and revise utilisation of evidence-based resources and skills in critical analysis
	CS2.3.2 Innovative approach to care of patients with multisystem and/or complex health issues is taken	**CS2.3.1.2a** Identify *useful and relevant resources* to refer to when assessing patients	**CS2.3.1.2b** Identify commonly used resources and their evidence basis	**CS2.3.1.2c** Support colleagues in utilising and critically interpreting evidence-based resources relevant to practice
		CS2.3.1.3a Describe and develop *skills in critical appraisal of resources*	**CS2.3.1.3b** Differentiate between the various levels of evidence for common therapies	
		CS2.3.1.4a Outline the challenges in applying *research evidence to individual patients*	**CS2.3.1.4b** Identify factors important in determining validity and relevance of research to an individual patient	
		CS2.3.2.1a Identify the role of, and *opportunities for, innovation in general practice*	**CS2.3.2.1b** Devise *strategies to manage clinical scenarios where evidence is lacking*	**CS2.3.2.1c** Facilitate appropriate research in clinical practice to improve health outcomes
		CS2.3.2.2a Identify opportunities to implement *harm minimisation and therapeutic intervention programs*	**CS2.3.2.2b** Practise *innovation to address obstacles in delivering quality of care in the community*	
CS2.4 GPs collaborate and coordinate care	**CS2.4.1** Appropriate *mode of care delivery* to suit the needs of the patient	**CS2.4.1.1a** Identify the *variety of models of care* provided in general practice	**CS2.4.1.1b** Distinguish patients for whom *care versus cure management* is appropriate	**CS2.4.1.1c** Review effectiveness of care coordination in the practice

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
	CS2.4.2 *Fragmentation of care* is minimised	**CS2.4.1.2a** Assess the *role of general practice in coordination of quality patient care*	**CS2.4.1.2b** Identify and *maintain skills in required care delivery models*	**CS2.4.1.2c** Evaluate and revise models of care delivery to optimise outcomes
		CS2.4.2.1a Identify the r*oles of health professionals involved in a care team*	**CS2.4.2.1b** Evaluate the criteria used to determine if a referral is appropriate for the individual patient	**CS2.4.2.1c** *Develop efficient systems to promote effective communication with other health professionals*
		CS2.4.2.2a Describe efficient strategies for effective communication in the care team	**CS2.4.2.2b** Implement efficient strategies to communicate with key health professionals involved in collaborative care	**CS2.4.2.2c** *Develop and maintain effective referral networks of individuals and groups within the community*
		CS2.4.2.3a Identify patients with chronic and/or complex health issues who would *benefit from* multidisciplinary care	**CS2.4.2.3b** Utilise the most effective mode of handover to minimise risks	**CS2.4.2.3c** *Support and mentor colleagues in establishing and maintaining networks of quality health resource providers*
		CS2.4.2.4a Outline the *key factors* to consider prior to making a referral	**CS2.4.2.4b** Identify and address potential barriers to effective communication with other health professionals	**CS2.4.2.4c** Effectively manage *conflict within a care team*
		CS2.4.2.5a Identify *key local and national organisations or individuals* who may provide resources to assist in quality patient care	**CS2.4.2.5b** Identify strategies to prevent fragmentation and facilitate delivery of quality collaborative care	
		CS2.4.2.6a Provide *timely and high-quality referral letters*	**CS2.4.2.6b** Establish and use referral networks of appropriate individuals and organisations that support health	
		CS2.4.2.7a Document and implement *appropriate follow-up and handover plans* that minimise risk and optimise health outcomes	**CS2.4.2.7b** Identify differences in care providers' opinions and negotiate agreement on management plans to optimise care	
	CS2.4.3 Demonstrate leadership in emergency situations	**CS2.4.3.1a** Identify factors that contribute to *effective teamwork in emergency situations*	**CS2.4.3.1b** Identify and manage *potential risks to the safety of others in an emergency situation*	**CS2.4.3.1c** Support and mentor colleagues to provide leadership in emergency situations

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
		CS2.4.3.2a Identify criteria by which to assess *appropriate time to withdraw treatment* in emergency situations	**CS2.4.3.2b** Address impacts on, and concerns of, family members and carers in emergency situations	
			CS2.4.3.3b *Communicate effectively with emergency and specialist services to optimise outcomes*	

Context and application: Domain 2

CS2.1 ***Holistic and patient-centred care*** – describes the ability to relate the diagnostic and management process to the available scientific evidence and the patient's:

- sociocultural context
- level of health literacy
- needs, values, goals and expectations
- any existing comorbidities
- health beliefs.

A holistic approach takes into account the patient's physical, psychological, cultural, social and existential dimensions when problem-solving, and seeks to develop and sustain patient collaboration wherever possible through empowerment by education, health promotion and goal-setting.

Respect for patient autonomy is a core ethical principle in the practice of medicine. It is the moral right of individuals to make their own clinical decisions if they have the capacity to do so and if not, be provided with support to identify a guardian who holds their best interests at the centre of any decision making.

CS2.1.1 ***Needs of the patient*** – health needs and expectations can vary significantly between individuals and if not recognised and addressed, can have a major impact on consequent satisfaction with healthcare delivery and clinical outcomes. It is therefore important to avoid making assumptions and to clarify individuals' specific needs and expectations in regards to factors such as style of communication and rapport with their GP, quality of care, discretion and confidentiality, knowledge base, ability to relieve symptoms and to provide continuity of care, etc. It is also important to identify factors such as the greater social roles and responsibilities of individuals, eg an elite athlete is more likely to be adversely impacted by an ankle sprain than an office worker.

Health needs also often expand to include family members and/or carers. GPs need to recognise when family members should be made aware of certain diagnoses, particularly areas such as reproductive health needs and genetic conditions for which screening is required or diagnoses which may impact the care needs of individuals who require support from a carer.

CS2.1.1.4a ***Manage unreasonable patient or carer expectations*** – it is important to identify when a patient, family member or carer has unrealistic or unreasonable expectations which may controvert the GP's professional and ethical responsibilities, including doctor–patient therapeutic boundaries, duty of care, confidentiality, or legislative responsibilities such as legalities regarding prescribing drugs of dependence. Strategies to manage these expectations may include:

- consistent management of drug-seeking behaviour (eg not prescribing at all or not without contacting other health professionals involved in care of the individual)
- applying for a permit and asking the individual to commit to an ongoing management plan (including referral to pain management services, etc)
- in the case of inappropriate behaviour toward the GP or practice staff, advising the individual that they are no longer welcome to attend the practice (after arranging follow-up care elsewhere)
- negotiating a code of conduct (to be signed by the patient) which, if breached, will lead to them not being able to attend the practice in the future
- informing family members about the importance of avoiding breaches of confidentiality, etc.

CS2.1.1.3b ***Challenges to delivering a patient-centred approach*** – may include:

- management of patients with complex PTSD, where attempted 'splitting' of health professionals in the team is common
- situations where the wishes of the patient are not well understood (eg individuals with severe cognitive impairment or intellectual disability, or who are floridly psychotic)

- patients who present seeking analgesics but are unwilling to be properly assessed – address other factors which may be contributing to their physical and/or psychological pain, or consider other therapeutic options.

CS2.1.2 ***Continuity of care*** – may be described as the quality provision of care over time. This should be viewed from the perspective of the patient, as a continuous caring therapeutic relationship with a provider they trust with whom they can communicate effectively, and the perspective of a GP, whereby there is a seamless transition through multidimensional models and types of care within the practice and externally with other health services. This care typically provides an integrated, coordinated framework which delivers quality care and optimises outcomes for the individual. Whichever form it takes, an integral part of continuity of care is to ensure that acute, undifferentiated and chronic conditions and abnormal results are followed up in a timely fashion to minimise risks and improve health outcomes, and that preventive care is delivered opportunistically.

CS2.1.2.1a ***Factors that support and contribute to quality continuity of care*** – may include the maintenance of respectful, effective communication and holistic patient-centred care over time. The maintenance of reliable and effective communication with other health providers involved in the care of the patients (refer to CS2.4.2.1) is an important factor which can contribute to this quality care. This can be facilitated by the effective use of eHealth processes and tools to maintain current and relevant medical records.

In addition, effective use of the personally controlled electronic health record (PCEHR)as a piece of public eHealth infrastructure that enhances the ability of clinicians to provide patient-centred care and which is a tool that connects GPs with other healthcare providers and health consumers, is also an important factor. The PCEHR allows GPs to create key pieces of health information with their patients, which then may be widely used and viewed by patients and other healthcare providers with important implications for patient safety and the provision of high-quality care.

CS2.1.2.2a ***Risks of not providing adequate continuity of care*** – principally refers to the risks of loss to follow-up in that individuals with abnormal results and/or serious diagnoses are not identified or managed effectively, leading to adverse health outcomes. Lack of continuity of care also misses opportunities for provision of health education, health promotion and screening, which can prevent or identify disease early and help to improve outcomes.

CS 2.1.2.3a ***Event and shared health summaries*** – refers to hospital discharge summaries, summaries within PCEHR tools and provision of documented information updates of changes in an individual's condition or management to relevant individuals within the health team, all of which improve quality of care.

CS2.1.2.1b ***Barriers to, and those that promote, continuity of care*** – professional barriers may include:

- the use of judgemental communication
- not using interpreters where necessary
- lack of cultural competence
- failure to acknowledge an individual's cultural bias or cultural lens
- failure to identify and address the health needs of an individual
- practice facilities which impair access (eg not appropriate for individuals from particular sociocultural groups, with disabilities, or who are employed full-time).

Patient barriers may include:

- issues which can impair the level of insight or capacity to engage with health services in a meaningful way (eg substance use or addictive disorder)
- drug-seeking patients who are unwilling to work collaboratively with their GP
- patients with delusional disorders, which impact their ability to participate in a therapeutic relationship.

CS2.1.3 ***Holistic management plans*** – involves engaging the individual, carers and family members in a therapeutic relationship where appropriate. This includes health education and promotion, preventive screening (for diagnosed disease complications or other diseases with common risk factors) and management to improve quality of life, clinical outcomes, enhanced work participation and reduce the risk of disease complications.

An effective management plan should include all relevant bio-psycho-socio-cultural risk factors that contribute to disease processes. This will help to define patient and health professional team goals and priorities, and facilitate access to appropriate community resources that are available from a physical and financial perspective. Enhanced primary care chronic disease management plans are available to assist individuals in accessing health services that would otherwise likely be unavailable due to financial concerns.

Advanced care directives are an important consideration in management planning for individuals with health conditions which are likely to deteriorate in the near future, enabling such individuals to clearly define their wishes to optimise the possibility of patient-centred care being delivered when the individual is no longer able to provide consent. When discussing the development of management plans, it is important to acknowledge holistic contributing factors to health (eg the benefits of meaningful work for individuals with physical and mental health problems), as well as review of contributing factors to illness or injury (eg biomechanics, ergonomics, recognition of modifiable risk factors and genetic factors to enable family screening).

CS2.1.3.2a *Individuals who would benefit from having a management plan* – incorporates most patients who attend general practices (although this does not solely refer to enhanced primary care management plans). This includes individuals with acute, severe, chronic and/or undifferentiated conditions that require intervention, follow-up, referral to other health providers or services, and/or establishment of criteria for review. These conditions include individuals with:

- depression
- schizophrenia
- anxiety
- PTSD and complex PTSD
- diabetes
- cardiac failure
- ischaemic heart disease
- epilepsy
- psoriasis
- chronic fatigue syndrome
- cancer
- children with recurrent otitis media
- asthma
- eczema, etc.

CS2.1.3.1b *Collaborative approach to management plan development* – this includes:

- acknowledging the sociocultural context and level of health literacy of the individual
- engaging in discussion and negotiation around available management options
- agreement on strategies attempted in the case of recurrence or relapse, including advice on when to seek medical help
- provision of adequate information to enable informed choice (eg obstetric delivery options, relapse prevention plans for patients with substance use or mental health issues, plans to manage potentially stressful future life events and stigma associated with the condition, return-to-work and activity plans based on knowledge of workplace systems and management)
- integrating pharmacological and non-pharmacological approaches for chronic pain management (eg rational prescribing of complex regimens of pain medication, comprehensive graded exercise programs, muscle strengthening).

Discussion around prioritisation of issues is an important part of collaborative plans (eg quality of life over prolongation of life), as is assessment, assistance and management of the functional impact of health condition on the individual.

CS2.1.3.2b *Management plans that are relevant to patient needs* – may include ensuring, where appropriate, that management plans are 'living documents' that are regularly updated when new diagnoses are made or changes occur, that plans are collaborative, and that individuals feel they are useful in order to help improve their health outcomes and reduce risk.

CS2.2 *Full range of health conditions* – includes multisystem disease and the broad range of acute and chronic physical and mental health issues, comorbidities and complications which present throughout the lifespan and affect all body systems. Some disabilities are often associated with comorbid conditions – bodily impairments that may occur simultaneously, such as cerebral palsy and epilepsy, and the conditions may be related to one another or distinct in their aetiology. A person with a disability is also exposed to secondary conditions, which are resultant from the primary disability (eg pressure sores in the immobile).

GPs should be skilled in assessment and identification of common acute (including emergency presentations), undifferentiated/well defined, and chronic conditions, and be confident in managing common conditions. Some individuals with ongoing undifferentiated conditions, complex common conditions or rarer conditions may require referral. This is viewed as a valid part of general practice management and the time at which this occurs varies depending on the context, and the skills and confidence of the GP.

CS2.2 *Across the lifespan* – refers to the full range of ages and life stages within which individuals present to general practice.

CS2.2 *Therapeutic relationship* – may be described as a helping partnership based on mutual respect and collaboration, where doctors and patients have a number of rights and responsibilities, particularly to contribute to shared decision making. Doctors have a duty of care to their patients, which includes a foundation of confidentiality, professionalism and ethics. Patients are encouraged to actively participate in their own healthcare, make informed decisions, and undertake recommended treatments, tests, referrals, and follow-up appointments.

Some important components of these relationships include consensus on treatment goals, commitment to activities of the therapeutic journey, and development of mutual confidence in one another. An effective therapeutic relationship is built over various encounters, actions and interactions and includes the use of quality communication with clear provision of information to enable the individual to make informed choices. Also important is the provision of a patient-centred approach in which the GP acknowledges the sociocultural context, needs and expectations of the individual and provides ongoing support throughout the investigation, diagnosis and management process. If an individual decides not to pursue a particular investigation or management option, the provision of ongoing support, follow-up and appropriate screening to minimise risks are important therapeutic considerations.

CS2.2.1 *Comprehensive biopsychosocial history* – may be used to describe a comprehensive approach to history taking which can assist in ascertaining the possible contributing factors to a clinical presentation and, therefore, the development of a meaningful management plan. This process acknowledges the impact of psychological factors (eg personality type, beliefs, past experiences, resilience, comorbidities) and environmental factors (eg concomitant social stressors, substance use, financial stress impeding access to functional housing, good nutrition and health services) on the patient's frame of reference, physical symptoms and biological disease states.

Comprehensive biological, psychological and social history includes current symptoms. For example, when assessing injuries it is important to consider taking a history of the mechanism of injury (evaluation of this utilises applied anatomy and physiology), obtaining a detailed description of experience of pain (which may assist in distinguishing pain mechanism) as well as past medical history, use of medications (including over-the-counter, and herbal and nutritional supplements), history of allergies, and occupational, relational and family history.

Family history includes documentation of a three-generation family tree, where appropriate, to identify modes of inheritance for conditions such as:

- haemochromatosis
- coeliac disease
- Down syndrome

- familial hypercholesterolaemia
- Factor V Leiden
- haemophilia
- polycystic kidney disease
- thalassaemia.

It is important to ensure sensitivity is used when exploring family relationships, including issues of adoption, paternity and consanguinity. Effective history taking should also include consideration of sensitive questioning about mental health issues and past or current exposure to trauma.

CS2.2.1.2a *Effective history taking documentation using the bio-psychosocial model* – refers to the importance of accurate, concise and structured recording of information conveyed in consultations. This will help other health professionals to easily understand what took place and assist in quality continuity of care. It is important to document factors such as:

- presenting symptoms
- possible associated risk factors
- family history
- allergies
- current medications
- relevant social history (eg smoking and alcohol intake)
- previous experiences which may adversely impact consultations (eg medical trauma).

CS2.2.1.4a *Identify potential impacts of sociocultural factors on presentation, engagement and compliance* – this includes consideration of potential factors which may affect how an individual presents with illness or in health, and their consequent ability to engage with the health service. These factors can include key gender differences (ie tendency for men to describe physical and externalising symptoms of depression more than emotional[1] and sexuality and gender issues in cultural minority groups.

CS2.2.1.1b *Identify priorities and negotiate an agenda* – achieved through respectful, effective communication with an individual, such as requesting a list of problems at the beginning of a consultation in order to enable both the patient and GP to identify key priorities. Reprioritisation of issues may be required if significant issues arise during the consultation, but this typically needs to be negotiated and timely, appropriate follow-up organised.

CC2.2.1.2b *Sensitively address psychological factors contributing to, or consequences of, physical symptoms* – may include recognising:

- somatic dysfunction, such as chronic pain and irritable bowel syndrome, which may or may not have an identified biological or physiological basis
- autoimmune conditions, such as rheumatoid arthritis, ulcerative colitis, psoriasis, eczema and hypertension, which are potentially associated with, or exacerbated by, psychosocial yellow flags like stress related to work, bereavement and exposure to family violence or previous trauma
- complex PTSD with its associated recurrent self-harming
- Munchausen syndrome or Munchausen by proxy,
- trichotillomania
- compulsive skin-picking causing unusual rashes
- weight changes related to eating disorders (these are predominantly psychological conditions which can primarily present with physical symptoms).

Identification of these conditions and the factors contributing to them is imperative, and evaluation of these possibilities in a non-judgemental and empathic way is important in order to ascertain the patient' perspective and insight to assist in the development of a meaningful management plan.

CS2.2.1.3b *Assessment tools* – those relevant to a GPs may include:

- mini-mental status examination
- suicide risk assessment (eg SAFE-T – Suicide Assessment Five-step Evaluation and Triage)
- Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA)
- Strengths and Difficulties Questionnaire (SDQ)
- Kessler Psychological Distress Scale (K10)
- Depression Anxiety Stress Scales (DASS)
- Edinburgh Postnatal Depression Scale (EPDS)
- psychosocial assessment tools for young people (eg HEADSS [Home and Environment, Education and Employment, Eating, Peer Related Activities, Drugs, Sexuality, Suicidality/Depression])
- developmental screening for infants and children (Australian developmental screening test)
- visual analogue pain scales and functional assessment charts to contribute to pain history
- pain scales for use in residential aged care facilities (eg Abbey Pain Scale, Pain Assessment in Advanced Dementia Scale [PAINAD], Non-Communicative Patient's Pain Assessment Instrument [NOPPAIN], Pain Assessment Checklist for Seniors with Limited Ability to Communicate [PACSLAC])
- GP Assessment Scale for Cognition (GP COG).

GPs need to have an understanding of the sensitivity, specificity and validity in the individual on which the tools are being used. This requires evaluation of the level of health literacy and other sociocultural factors, such as language and cultural background.

CS2.2.2 *Appropriate and respectful physical examination* – may be defined as undertaking an examination which is appropriate to the presenting complaint, age and gender of the patient, in a comprehensive way that preserves the dignity and maximises comfort, involvement and safety of the patient (eg use of privacy screens and sheets for women when undertaking, breast, genital and/or pelvic examinations). It is important to ensure the examination occurs following clear explanations which allow informed provision of consent.

The use of tools to aid physical examination may vary depending on the remoteness and context of clinical setting, but may include visual acuity charts, (pan) ophthalmoscopes, auroscopes, hearing tests, slit lamps, biomechanical assessment testing, Rinne and Weber tests, ultrasounds and dermatoscopes, etc.

CS2.2.2.1a *Informed consent prior to undertaking a physical examination* – requirements for informed consent vary based on a number of factors, such as the history of the therapeutic relationship, type of examination, sociocultural factors (eg need for a gender-concordant health professional), and history of the patient (areas like sexual abuse or medical trauma).

Obtaining consent does not necessarily mean a prolonged discussion is required before every physical examination. Consent is often implied in the case of patients with whom the GP has established a therapeutic relationship and can be checked by simple requests such as, 'Is it okay if I examine you now?' However, a more detailed explanation is often advisable in the case of patients who require more intimate examination (eg genital or breast). This helps to explain the reasons why such an examination needs to be undertaken, and to check whether the patient has any objections or requirements (eg the presence of a chaperone).

CS2.2.2.3a *Barriers to physical examination* – may include individual requests for gender-concordant care, individuals with body dysmorphia declining physical examination due to embarrassment or anxiety, and individuals who have experienced sexual assault or abuse who fear having PTSD triggered. There are many complex reasons and beliefs as to why individuals may decline examination and it is important for the GP to be empathic and non-judgemental and use sensitive questioning to develop an understanding of the reason(s) for concern.

Once the basis of the individual's concerns are understood, a plan as to how their health needs can be met can then be negotiated. This may include referral to another gender-concordant GP, presence of a chaperone, counselling regarding fears and anxieties, etc.

CS2.2.2.4a *Acquire positive and relevant negative signs to assist in diagnosis* – it is important GP establish a list of differential diagnoses based on history and knowledge of the patient prior to undertaking a physical examination, and be mindful of the relevant positive and negative signs to seek out which will assist in clarifying the most likely diagnosis.

CS2.2.2.5a *Situations where physical examination findings are inconsistent with history* – important conditions to consider include:

- causes of non-accidental injury (including concerns about intimate partner or family violence)
- individuals at risk of intentional self-harm (eg misuse of medication, disordered eating, cutting, etc) such as occurs in complex PTSD or recurrent somatic complaints which remain undifferentiated, despite investigation where there is a suspicion that there may be a psychological basis
- stress related to being a carer, recent bereavement, work/career, finances, potential for secondary gain
- Munchausen syndrome or Munchausen by proxy.

CS2.2.2.1b *Strategies that ensure patient comfort* – may include:

- clear communication about the purpose of the examination
- obtaining informed consent
- ensuring that privacy and dignity are paramount
- regular checking back with the patient during examination to ensure that they are comfortable
- optimising sense of empowerment of the patient by ensuring that they feel comfortable to stop the examination at any point if they are uncomfortable, etc.

CS2.2.3 *Significantly ill* – a term which may be used to describe an individual at any life stage who is at risk of actual or acute potentially life-threatening health problems. Early identification of significant illness managed in line with accepted guidelines can often improve outcomes.

Important critical illnesses can be grouped in a variety of ways, including:

- by age or life stage, such as paediatric presentations (eg epiglottitis, bronchiolitis, croup), obstetric (eg antepartum haemorrhage, preeclampsia, ectopic pregnancy) or end-of-life emergencies
- system or body region affected (eg orbital cellulitis, acute glaucoma, ocular trauma)
- chest pain (eg acute coronary syndromes, pulmonary embolism, aortic dissection)
- acute cerebrovascular events (eg cerebrovascular ischaemia, intracerebral haemorrhage, assessment of collapsed patient)
- mental health emergencies (eg acute psychosis, high-risk suicidality)
- acute abdominal pain (eg bowel obstruction, appendicitis, abdominal aortic aneurysm)
- respiratory compromise (eg severe asthma, COPD, pulmonary embolism, pneumonia)
- metabolic problems (eg ketoacidosis, Addisonian crisis, acute renal failure)
- dermatological problems (eg Stevens–Johnson syndrome, pustular psoriasis)
- urologic problems (eg priapism, acute urinary obstruction)
- causative factors or mechanism (eg anaphylaxis)
- infections (eg meningococcal meningitis, septic shock, eczema herpeticum, necrotising fasciitis)

- major trauma (eg head, face, chest, traumatic pneumothorax, abdomen, visceral rupture, pelvis, spine)
- illicit or prescription drug overdose or serious adverse effect (eg heroin overdose, serotonin syndrome, oculogyric crisis)
- envenomation or poisoning (eg snake and spider bites)
- oncological emergencies (eg spinal cord compression, superior vena cava syndrome, hypercalcaemia, bowel obstruction, tumour lysis syndrome, bone marrow suppression).

CS2.2.3.1a *Identify a significantly ill patient across the lifespan* – includes the key features which, on initial assessment, flag that there is a risk of further deterioration. Infants can deteriorate very quickly and thus require careful assessment. Symptoms and signs include reduced feeding and looking 'floppy' when unwell, as well as signs of dehydration. In addition, increased respiratory effort and decompensation are very important to elicit in children under 12 months of age (eg cool peripheries, greater respiratory rate with increased work of breathing, poor skin turgor, sunken fontanelle).

Toddlers tend to not be interested in playing or engaging with surroundings when unwell, and tachycardia is usually the first physical sign of decompensation. Fit young adults often maintain blood pressure until condition deteriorates and very severe tachycardia can occur for hours before clinical hypotension. Older people or those with chronic conditions, can experience hypotension early on and tachycardia may be masked by pre-existing conditions (eg heart block) or use of medications (eg calcium channel or beta blockers).

CS2.2.3.2a *Criteria used to determine when acute resuscitation should be instituted* – includes:

- absence of danger to attendees
- identification of loss of consciousness
- lack of normal breathing and/or loss of palpable pulses
- absence of a not-for-resuscitation order (eg advanced care directive documenting patient's wish to not be resuscitated).

CS2.2.3.3a *An efficient treatment plan to optimise outcomes* – may include rapidly prioritising issues to manage, including the DRSABCD action plan (Danger, Response, Send for help, Breathing, CPR, Defibrillation), in line with Australian Resuscitation Council (ARC) guidelines, remembering to prioritise health of yourself and others assisting before starting CPR and engaging help from a senior colleague or emergency services early on in resuscitation.[2]

CS2.2.3.4a *Contemporary practice of basic life support* – refers to developing skills and confidence in utilising basic life support protocols according to the most current version of the ARC guidelines.

CS2.2.3.1b *Manage clinical presentations of acute serious illness and trauma efficiently and appropriately* – the range of emergency presentations that may occur in general practice is broad (refer to CS2.2.3 for example) and the skills required in management are directly related to the context of the general practice setting. GPs should maintain confidence in their level of emergency management skills and be cognisant of the need to access assistance when required. Appropriate management of emergency presentations includes utilising evidence-based guidelines (eg ARC guidelines).

CS2.2.3.2b *Emergency management skills* – refers to the need to maintain skills which are appropriate to the general practice environment and access to specialised emergency services.

CS2.2.3.3b *Maintain competence in basic and advanced life support* – assessed by participating and obtaining a certificate of competence in ARC-approved training on a three-yearly basis.

CS2.2.3.2c *Debrief colleagues as required following management of a significantly ill patient* – it is common for health professionals to experience stress reactions following involvement in a critical incident. These can range from uncomplicated stress reactions to more complex PTSD responses. The response of health professionals and their ability to seek out psychological support can be negatively impacted by feelings of guilt, fear of litigation or disciplinary action. This means that having structures by which all individuals involved in a stressful event are

invited to group or individual debriefing can be very useful in exploring emotional responses and providing support, as well as assessing whether there is anything to be learned from the experience. It is important to recognise that experienced practitioners are not immune to the need for debriefing following stressful events.

CS2.2.4 ***Rational list of differential diagnoses*** – may be used to describe the process of developing a list of conditions which are most likely in a given clinical scenario after acknowledging the individual's background and context and undertaking history and examination. In order to minimise risk, this should highlight the possible spectrum of disease, prioritising the most important conditions to exclude due to their potential severity, through to those which are least likely and therefore at least risk of causing harm to the individual. This process should then support the practitioner in creating a rational investigation and management plan.

CS2.2.4.1a ***Variations of normal physiology and psychology from pathological ones*** – may include:

- distinguishing 'normal' psychological responses to stress and grief from 'abnormal' responses and variations which may occur between sociocultural groups
- identifying functional from dysfunctional personality traits
- acknowledging variability in physical and psychological effects of various life stages and ageing on different individuals
- variations in signs like normal range of movement of joints during musculoskeletal examinations (eg ability to identify hypermobility syndrome)
- identifying variations of normal skin (eg ephiles) from pathological ones
- normal trajectories of decline in older people compared to the degree of decline related to disease processes.

Some examples of 'normal' life stages which need to be distinguished from pathological processes include:

- puberty (need to identify precocious puberty)
- menarche and early menses (need to identify endometriosis)
- menopause (distinguish from premature menopause and identify perimenopausal symptoms which are negatively impacting quality of life and thus may require intervention)
- differentiation of andropause from normal ageing in men
- pregnancy/fertility (distinguish from subfertility or infertility)
- developmental milestones (significant deviations from these in childhood and adolescence).

CS2.2.4.2a ***Principles and criteria used to develop differential diagnoses*** – may include utilisation of clinical flags as a structure to assist in prioritisation of issues. Clinical flags include:

- red (possibility of serious pathology)
- yellow (psychosocial pointers which may indicate risk of progression to long-term distress, disability and/or pain)
- orange (psychological equivalent of red flags, suggest need for mental health review)
- blue (perceptions about the relationship between work and health which may inhibit recovery)
- black (systemic or contextual obstacles related to particular people, systems or policies).

Consideration of all of the relevant factors to the individual assist in recognising the multidimensional aspects of conditions, particularly pain, and assist in risk stratification and the development of a meaningful management plan.

CS2.2.4.2b ***Stratify risk of differential diagnoses*** – involves the assessment of the individual's risk of having a disease state based on the information available. This information includes knowledge of the individual's clinical flags and other risk factors, particularly family history and mode of inheritance of the condition, as well as lifestyle factors, concomitant disease and medication history.

CS2.2.4.4b *Identify and manage non-accidental injury* – includes identifying patients who present with physical signs and symptoms which are inconsistent with the history provided and who may be at risk of family violence, child abuse, elder abuse, sexual abuse or intentional self-harm. Once a possibility of non-accidental injury has been raised, it is important to sensitively and empathically discuss this with the individual in order to ascertain whether they are currently safe and, if child protection concerns are raised, to discuss the need for mandatory notification. Engage in non-judgemental discussion with active listening, debriefing and/or counselling, and provide support and information which will enable the individual to return for review when needed or to access other support services to enable them to minimise future risk.

CS2.2.5 *Appropriate procedures* – may be used to describe those procedures which are likely to be most beneficial to the individual's health and wellbeing from a diagnostic and/or management perspective. Assessment of the appropriate nature of procedures is inherently related to the practice setting (ie urban versus rural and remote), individual sociocultural context and consequent availability of access to more specialised services. Recommendations for such procedures should consider the potential benefits, taking into account the evidence basis and the possible risks and costs in the context of any relevant sociocultural beliefs of the individual.

Decision-making and processes around procedures include:

- choosing the appropriate procedure
- communicating clearly with the patient
- obtaining and documenting informed consent
- safely performing the procedure using strict infection control standards
- accurately documenting what took place.

The range of procedures which may be deemed appropriate for general practice includes:

- eye procedures (eg the use of ocular cycloplegics, topical anaesthetics and/or fluoroscein to assist in eye examination, removal of a corneal foreign body, eyelid eversion)
- removal of foreign bodies in ears and nose
- nasal cautery/packing for epistaxis
- guided and unguided musculoskeletal injections (eg trigger point, joint, bursal, intra-articular, carpal tunnel, nerve blocks)
- acupuncture or dry needling
- patient blood management (eg intravenous iron infusion and venesection for haemochromatosis)
- dermatological procedures (eg biopsy, shave, punch, excisional biopsy cryotherapy, electrocautery, diathermy, skin and nail scrapings for fungal disease, skin swabs for bacterial or viral disease, injection of keloid scar, drainage of abscess)
- ingrown toenail surgery
- suturing
- application of plaster for fractured limbs.

CS2.2.5.2a *Quality informed consent regarding procedures* – based on a clear appreciation and understanding of the facts, implications and consequences of undergoing a 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. The patient must demonstrate adequate reasoning faculties and be in possession of all relevant facts at the time consent is given.

Factors which may influence the patient's ability to provide informed consent may include impaired cognitive function, language barriers, low level of health literacy, etc (refer to CS5.2.2).

CS2.2.5.3a *Factors that influence which procedures may be undertaken safely in general practice* – it is imperative to ensure the development and maintenance of procedural skill competencies are in line with medical registration criteria. This includes skills in management of complications, which helps to minimise potential medico-legal consequences as well as any potential harm to patients. Continuing surveillance for trends in procedural risk complications in reports from medical boards, and alerts and bulletins from medical defence organisations and surveillance authorities provides an important opportunity to identify and minimise adverse risk associated with medical procedures. 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. This is particularly important in the case of infection control standards relating to the safe handling of body fluids and substances, the clinician's responsibilities regarding blood-borne virus transmission, and the avoidance and management of needlestick injuries. Use of simulation-based teaching techniques to acquire and practise skills is highly recommended.

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 their procedural participation to those tasks for which they can demonstrate competence. GPs with a special interest area, or who are undertaking additional procedures, must ensure their skill levels meet the recognised standards/curriculum requirements for procedural skill competency acquisition and maintenance (eg special training for Implanon insertion, advanced rural skills training such as the RACGP Fellowship in Advanced Rural General Practice (FARGP), RACGP Joint Consultative Committees and jurisdictional requirements/standards).

CS2.2.5.1b *Appropriate procedure based on patient's need and context* – includes being aware of the procedure options and undertaking the most potentially beneficial to treat the condition, with minimal risk, after appropriate counselling and obtaining informed consent from the patient.

CS2.2.5.2.b *Appropriate medical procedures and aftercare with informed consent* – refers to the importance of clear documentation, which may include:

- which procedure was undertaken
- whether informed consent was obtained
- the indications for the procedure
- any adverse events
- what information was provided to the patient regarding aftercare
- whether a review appointment was organised.

CS2.2.6 *Rational options for investigations* – may be defined as the diagnostic tests which are likely to be most beneficial to the health and wellbeing of the individual. Recommendations for such referrals should be evidence-based (eg magnetic resonance imaging [MRI] and prostate specific antigen [PSA] referral guidelines) and consider the balance between potential benefits, considering the evidence basis and available resources and guidelines (including from a societal health economic perspective) against the possible risks and costs. The decision-making should occur within the context of the sociocultural beliefs of the individual after provision of adequate information to enable informed consent.

CS2.2.6.2a *Factors to consider when choosing the most appropriate investigations* – considerations may include:

- being aware of the purpose of referral for investigation and whether a positive or negative result will alter the management plan (eg a tissue diagnosis is usually essential to guide management in patients with suspected cancer)
- the evidence basis of the different investigation options
- evaluation of the validity, sensitivity and specificity of investigations
- the cost and risks of investigations (both to the patient and to society through Medicare funding), etc.

CS2.2.6.2b *Limitations, risks and benefits* – need to be based on the best available and current evidence and include information about the potential harm caused by some investigations, such as multiple CT scans, or the sensitivity and specificity of some tests (eg PSA), including information on false positives and false negatives, where further investigation and treatment may pose risks, and pre-test counselling for blood-borne viruses in an individual who is at risk of possible exposure to ensure that the concept of the window period and need for follow-up is understood.

Risks, costs of investigations, and possible treatment options in the event the investigations are suggestive of disease should be discussed prior to the investigation being undertaken. These discussions may include financial costs of the investigation and potential for increased insurance costs if a suspected diagnosis is confirmed (eg Factor V Leiden heterozygote).

Effective counselling should be provided regarding the possible implications of predictive predisposition testing for later onset disorders to assist in gaining informed consent. This is particularly true in situations where there are few treatment or risk-mitigation strategies available (eg Huntington's disease), the options for treatment involve risks, the development of the condition is not a certainty (eg option of radical mastectomy and/or oophorectomy for women with BRCA1 and BRCA2 genes compared to ongoing surveillance screening). These issues need to be discussed prior to the genetic testing being undertaken.[3]

CS2.2.6.1c *Review and compare investigation referral patterns with peers* – this is done to ensure that referral patterns are reasonable and rational. If significant variations are found, ensure that referral patterns are in keeping with current guidelines (if available) and that you are able to justify the variations in regards to potential benefits and minimisation of risks and costs.

CS2.2.7 *Results of investigations are interpreted in the context of the patient* – refers to the skill set required to identify the significance of abnormal or, in some cases, normal investigation results for the individual in the context of their relevant past and family history, current symptoms and medications. An understanding of the physiological impacts of ageing and disease processes is an important aspect of result interpretation, such as:

- understanding the significance of low normal platelets and low-level elevation of transaminases in individuals with hepatitis B
- ideal ferritin targets for individuals with haemochromatosis
- HbA1C targets for individuals with type 1 and type 2 diabetes
- acceptable creatinine levels in an individual with chronic renal impairment
- mildly elevated bilirubin in patients with Gilbert's syndrome.

CS2.2.7.2a *Effectively communicate relevant results, integrating the context of the individual* – refers to the need to incorporate your knowledge of the patient, including level of health literacy, expectations, and previous experience with health services, past history and family history, to communicate with them in a clear and rational way. This may include discussion around abnormalities which do not necessarily correlate with symptoms (eg disc prolapses on CT scan in patients without back pain or neurological symptoms).

CS2.2.7.1b *Strategies to ensure that results are reviewed and interpreted* – refers to the importance of individual GP and practice structures to ensure that results are checked and appropriate actions are taken as a result. There should be clear handover processes within a practice when leave is taken, as well as routines for ensuring that results are checked (eg abnormal Pap smears and mammograms). Patients should be informed of their responsibilities and the practice processes of being informed of their results.

CS2.2.8 *Diagnosis and management is evidence-based* – includes identifying modifiable risk factors and early recognition of physical and psychological conditions in order to provide effective health education, promotion and appropriate management. Management may include the broad range of therapeutic options, including no active intervention to lifestyle modification (including changes to diet, stress modification and exercise regimens), medical therapies (eg pharmaceuticals and/or herbal and nutritional supplements), physical therapies (eg physiotherapy, osteopathy, hand therapy, etc), psychological approaches (eg meditation, psychological and trauma counselling), surgical procedures, and return-to-work planning.

The decision to pursue one or multiple treatment options is made following provision of education and advice related to options in order to enable informed consent and after consideration of the:

- presentation
- existing evidence and guidelines
- risks and benefits of the various options
- values, beliefs and sociocultural context of the individual
- ability to access treatment from a financial or physical point of view.

This approach optimises health outcomes and reduces risk of complications and progression in acute and chronic conditions.

CS2.2.8.1a *Approaches to communicating evidence effectively to patients* – may include exploration and acknowledgement of the level of health literacy, values, preferences and health belief system of the individual, and tailoring the way in which the information is conveyed in order to assist in collaboration and achieve patient-centred care. Typically, the GP and patient view health through very different lenses:

- Doctors approach health from a Western biomedical model and may think in terms of probabilities applicable to populations, rather than individual patients.
- Patient perspectives may be based on a combination of personal experience, interpretation of scientific evidence through mass media, and 'common sense' understandings of health and illness.

These differences mean it is important for both parties to be prepared to respect the other's frame of reference and clearly articulate their own perspective and preferences.

CS2.2.8.2a *Treatment options* – includes physical, social and psychological therapeutic modalities which are likely to be of most benefit to the health and wellbeing of the individual, taking into account sociocultural beliefs and balancing the risk of side effects, interactions and costs. These may include:

- advice on exercise regimens, dietary improvements and sleep routine
- adequate sun exposure
- involvement in community activities
- stress management techniques
- communication strategies
- conflict resolution with significant others
- avoidance or minimisation of exposure to risk factors like smoking, alcohol, illicit substances, environmental pollutants, etc
- pharmaceuticals
- herbal or nutritional supplements
- referrals for physical or psychological therapy, or to other specialists for different forms of intervention or management
- addressing social determinants of health.

CS2.2.8.1b *Effective counselling regarding management options* – includes discussion of possible outcomes and uncertainties of treatment options. This includes balanced communication regarding risks versus benefits in language appropriate to the individual and their sociocultural context to enable informed consent. For example, non-judgemental, non-directive counselling about care options for unintended pregnancy, including medical termination if appropriate, oncology treatments, chemotherapy, radiotherapy, and integrative and palliative care treatments and procedures.

CS2.2.8.2b *Formulate safe strategies to provide care for patients who decline evidence-based management options* – may include individuals who opt to access non-evidence-based treatment as an alternative to, or in combination with, no treatment rather than evidence-based options. It is often important for GPs to take a non-judgemental approach and offer of ongoing support for monitoring, review, education and health promotion. It is also important that GPs be adequately informed about alternative options for management and ensure that they are aware of potential interactions and contraindications. Maintaining an open dialogue with patients helps to facilitate discussion about other therapies they may be accessing and assists in optimising safety and the provision of quality, collaborative care.

CS2.2.8.3b *Primary, secondary and tertiary prognostic factors* – prognostic factors may differ from risk or predictive factors: risk factors are associated with causing a condition, whereas prognostic factors are those which in people with the condition influence the outcome. There is some crossover with prognostic and predictive factors. For example, in the case of women with breast cancer, primary prognostic factors such as tumour size, presence of axillary lymph node involvement and hormone receptor positivity all determine the treatment recommended regimen, and secondary prognostic factors such as level of exercise and diet are thought to contribute to risk of recurrence.

CS2.2.9 *Rational prescribing and medication monitoring* – refers to evidence-based prescribing, utilising accepted guidelines combined with consideration of individual factors regarding contraindications or warnings, particularly any issues regarding individual capacity, to safely metabolise medication (eg patients with renal or hepatic impairment, or who are pregnant or breastfeeding).

Age is also an important factor. This is partly related to metabolism and decisions regarding dosing, but also to effectiveness of medication, including those used for prevention, such as statins, which are unlikely to be of benefit in older people. Other factors include capacity for compliance and concomitant medications (eg other pharmaceuticals, and herbal and nutritional supplements) with risk of interactions.

'Medications' refers to appropriate topical ocular and aural agents, dermatological agents, rational use of antibiotics, sedatives, analgesics (including those used for acute and chronic pain management). It is important to consider regular clinical audits of analgesic, antibiotic and/or sedative prescribing in order to ensure this occurs within recommended guidelines and legislative frameworks.

CS2.2.9.1a *Key factors to consider when selecting the most appropriate medication* – may include considering the age, concomitant medications and comorbidities of the patient and, thus, their physiological ability to metabolise the medication and tolerate potential side effects. It is very important to balance the potential benefits of the medication with potential risks, consider the possibility of placebo response, consider the cognitive capacity of the individual to manage potentially complex medication dosing, recognise potential side effects, and consider financial cost.

Individuals should be provided with adequate information about the potential risks and benefits, need for review and therapeutic monitoring, and potential interactions with other medications (eg St John's Wort) or particular foods (eg those that contain vitamin K and warfarin) in order to enable informed consent. The occupation and other responsibilities of the person is another factor to assess, particularly in regards to potentially sedative medication or for individuals who are elite athletes.

'Medication' includes pharmaceutical medications (prescribed and over-the-counter), as well as herbal and nutritional supplements. It is important to consider certain factors specific to particular groups of medications, such as the need for regular monitoring (eg regular INRs with warfarin and being confident that the individual is able to comply), need for titration of dosing, opioid equivalents of different analgesic medications, and where relevant, 'wash out' period of medications to ensure that changeover to an alternative occurs safely (eg with antidepressants).

CS2.2.9.2a *Useful evidence-based guidelines to assist in prescribing appropriately* – include:

- unbiased resources to assist with rational antimicrobial prescribing (eg antibiotic guidelines)
- appropriate and judicious use of chemical (and physical) restraints in patients with impaired cognition as a last resort (eg psychotropic guidelines)
- appropriate analgesic prescribing (eg analgesic guidelines)

- the *Australian Medicines Handbook*[4]
- Pharmaceutical Benefits Scheme (PBS)
- other therapeutic guidelines.

Other important resources to consider are those which detail evidence-based integrative therapies and interactions with conventional treatments, and drugs in sport guidelines regarding banned substances, etc.

CS2.2.9.3a *Safety and compliance* – may include providing adequate verbal and/or written information about the medication prescribed. This information should take the sociocultural context of the patient into account and can include a list of common side effects, any important drug and/or food interactions, and explanation of the need for therapeutic monitoring or screening (eg pelvic ultrasound with tamoxifen use) in order to enable informed consent, etc.

CS2.2.9.4a *Common prescription and over-the-counter drug interactions* – include:

- St John's Wort and selective serotonin reuptake inhibitor (SSRI) antidepressants
- warfarin and aspirin
- phenytoin and alcohol
- combined oral contraceptive pill and certain antibiotics.

CS2.2.9.5a *Principles of pharmacotherapy withdrawal* – relevant to a number of groups of medications, including benzodiazepines, antidepressants (particularly venlafaxine) and opioids. There are guidelines to assist in recognising and assisting in management of withdrawal symptoms to optimise safety for patients, including:

- *Therapeutic Guidelines: Psychotropic version 7*
- *National guidelines for medication-assisted treatment of opioid dependence*
- *Alcohol and other drug withdrawal: Practice guidelines*
- *Graylands Hospital drug bulletin: Antidepressant switching strategies*.

CS2.2.9.2b *Identify role of off-label prescribing and implement risk minimisation strategies* – off-label prescribing refers to a medication for an indication or patient group that is not included in the approved product information. This does not mean that the Therapeutic Goods Administration (TGA) has rejected the medication for use in this indication or group, but is often due to a lack of evidence in this group, which may be due to the group being small and thus providing little motivation for the drug company to register for this purpose.

Off-label prescribing needs to be approached rationally and from an-evidence based perspective. If the prescriber believes that there is adequate evidence for the use and safety profile for the individual, then it may be reasonable to prescribe it. However, it is important that the patient is aware that the medication is being prescribed off-label and that there consequently may be different review or follow-up processes required to ensure that adverse effects are detected early.

CS2.2.9.3b *Robust strategies to monitor for medication side effects and risks of polypharmacy* – includes planned medication reviews to enable monitoring for acute and chronic side effects. This allows dosage or medication changes, appropriate referrals for home medicines review for patients prescribed multiple medications or where there are concerns about compliance or safety, etc.

CS2.2.9.4b *Report medication side effects appropriately* – relevant authorities include the TGA's Database of Adverse Events Notification (DAEN), within which notifications regarding conventional and integrative medications can be made, and the National Centre for Immunisation Research and Surveillance.

CS 2.2.9.5b *Address barriers to medication compliance* – may include:

- effective communication with patients about the role of medications
- discussion about patient concerns or reticence
- ensuring patients are aware how and when to contact you if they have concerns about a medication or side effects

- organising regular review to ensure that medication is being tolerated and is effectively treating the condition for which it is prescribed
- use of the 'Webster-pak' to assist with compliance for patients who are taking multiple medications or who may have cognitive impairment which impacts their memory
- referral to district nursing service or enlisting family help to assist with medication management
- ensuring maintenance of current medication records
- ensuring utilisation of home medication reviews with a local pharmacist
- ensuring patients have access to quality information to assist in compliance.

CS2.2.9.6b *Quality care to patients who decline recommended medications* – refers to individuals who, due to personal experience, health, or religious or cultural beliefs, do not believe that a particular medication is suitable for them. It is imperative to ensure that individuals are provided with quality information which is appropriate to their level of health literacy to ensure that they are able to provide fully informed consent. These patients need to fully understand the likely consequences of their choice and be made aware of all of the management options available to them.

Maintaining an effective therapeutic relationship in this situation can be challenging, but should be provided every opportunity to develop through non-judgemental and open communication. The GP should seek to understand the beliefs, perspectives and values of the individual in order to continue to support them. Other strategies may include attempting to organise regular review and monitoring for progression of the condition for which the medication was recommended, as well as ongoing support and education about possible alternative options.

CS2.2.9.7b *Medication misuse and withdrawal* – may include recognising the most commonly misused and/or abused medications which are sought out by individuals who want to them for non-medically indicated reasons, such as injecting oral medications, overusing prescribed amounts or selling medications on the street (eg opioids, benzodiazepines, sedating antipsychotics). Identifying possible signs of inappropriate use of drugs of dependency can include patients who:

- present close to the practice's closing time without an appointment
- request a specific drug and refuse all other suggestions (may also display considerable knowledge of drugs)
- typically request short-acting or injectable forms of drugs
- present with inconsistent symptoms (eg does not appear to suffer significant pain)
- decline referrals for therapy
- report a recent move into the area from somewhere beyond the vicinity of the practice, making direct validation of prescribed drug supply with the previous practitioner difficult (any supporting letters apparently from previous practitioners should be checked when possible)
- are awaiting admission to hospital
- demonstrate scars, or present old X-ray or investigation reports (may not be authentic)
- state that they have lost their last script
- admit to injecting oral formulation
- admit concurrent abuse of alcohol or illicit substances
- have a history of multiple non-sanctioned dose escalations
- report psychic effects of using medication not intended by a prescribing clinician.

Careful observation of patients may be useful in identifying them as drug users. Look for signs of drug use, intoxication and withdrawal:

- Benzodiazepine intoxication is characterised by sedation, poor coordination and balance, impaired memory and general impairment of cognitive function.

- Benzodiazepine withdrawal is characterised by anxiety, irritability, palpitations and tremor.
- Opioid intoxication patients may present with pupillary constriction, itching nose and skin, difficulty concentrating, dry mouth, and visible injection-site marks.
- Opioid withdrawal is characterised by dilated pupils, increased heart rate and blood pressure, diarrhoea, muscle cramps, aches and pains, frequent yawning, rhinorrhoea and lacrimation.

It is important to note that opioid-dependent patients may seek benzodiazepines, particularly if they are experiencing withdrawal and want these drugs to alleviate some of the symptoms.

It is helpful to have a good understanding of their pharmacological and pathophysiological effects in order to manage what appear to be inappropriate requests for these medications. Reasons for misuse of medications are broad and varied. An important part of recognising and managing misuse is seeking to understand the motivations and/or needs of the individual (eg recognition of concomitant mental health or illicit substance-use issues for which the individual may be self-medicating). Once the motivations and needs are understood, a management plan can be established to address the medication use and develop strategies to minimise the risks and impacts. Strategies may include:

- regular review
- referral to appropriate support or specialist services (eg pain management clinics or mental health services)
- utilisation of opiate substitution and pharmacotherapy
- application for appropriate jurisdictional health department permits for prescribing drugs of dependency to a drug-dependant person (refer to CS2.2.9.8)
- development of an agreement between the GP and patient as to acceptable behaviour and actions in the event particular situations arise
- contacting the Department of Health Prescription Shopping Information Service (PSIS).[5]

CS2.2.9.8b *Restricted medications using appropriate permits* – examples of Schedule 4 and Schedule 8 medications (common drugs of dependence) include:

- benzodiazepines (particularly alprazolam and flunitrazepam)
- codeine (when not combined with any other medicine)
- buprenorphine
- fentanyl
- hydromorphone
- morphine
- oxycodone
- pethidine
- methadone
- dexamphetamine
- methylphenidate.

Legislative requirements vary between states and territories. It is important for GPs to be aware of the legislation within the jurisdiction in which they practice, to take all reasonable steps to confirm the identity of the patient, and to ensure that a therapeutic need exists.

Safe prescribing includes:

- avoidance of injectable opioids
- clear and accurate records regarding rationale for prescribing
- date and quantity of scripts provided to ensure that higher than prescribed doses are not being used

- pain management plans for patients prescribed opioids being in place; ensuring that patients are referred to pain management specialists if more than the maximum recommended dose is prescribed.

CS2.2.9.9b *Conflicts of interest* – refers to the importance of acknowledging and addressing any biases an individual may have which may impact prescribing habits that are not in line with evidence-based guidelines (eg the GP having a pecuniary interest in a particular treatment being prescribed, or being incentivised through other means to prescribe a particular treatment).

CS2.2.9.3c *Up-to-date prescribing knowledge* – refers to the importance of maintaining currency with changes to prescribing practices. This can be done through staying up-to-date with guidelines and legislative changes and undertaking training in general practice-specialised medication prescribing if suitable for your patient population (refer to CS2.2.9.5c).

GPs can also benefit from maintaining awareness of the development of new technologies to personalise pharmaceuticals through pharmacogenomics, which utilises information about an individual's genetic make-up to assist in effective pharmaceutical prescribing. Current examples include prescribing;

- abacavir (anti-retroviral drug) – doctors now routinely test HIV-positive patients for a genetic variant that makes them more likely to have an adverse reaction to the drug
- trastuzumab (breast cancer drug) – this therapy works only for women whose tumours have a particular genetic profile that leads to overproduction of the HER2 protein.

CS2.2.9.4c *Specialised prescribing* – may include undergoing specialised training, supervision and gaining clinical experience in s100 prescribing for conditions such as tuberculosis, HIV, hepatitis B.

CS2.2.10 *Ongoing undifferentiated conditions* – can cause considerable anxiety in both GPs and patients, and highlights the need for a structured approach which is evidence-based and minimises risk from health and economic perspectives. The range of common ongoing undifferentiated conditions in general practice includes such presentations as:

- fatigue
- insomnia
- cough
- dizziness
- anorexia
- nausea
- sexual difficulty
- weight and appetite loss
- chronic pain (including headache, chest, back, pelvic and abdominal pain, which have been explored clinically and investigated, where appropriate, with no precise diagnosis being made).

In these clinical situations, a management plan typically needs to be formulated in the absence of a diagnosis. A management plan may be framed in terms of dichotomous decisions: treatment versus non-treatment; referral versus non-referral; and serious versus non-serious. 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. Understanding the role of the passage of time, effective communication skills, and knowledge of the natural history of these conditions are key in managing undifferentiated conditions.

CS2.2.10.1a *Areas of risk in managing patients with undifferentiated conditions* – 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. Clinical decision-making around choices of investigations and management need to be rational and balance the potential risks (of both under and over investigating and management) against the benefits in the context of the individual.

The role of uncertainty in clinical outcomes remains unclear. Uncertainty in clinical decision-making has been linked to potential and actual adverse outcomes in patient care in the prevocational setting. Clinical strategies for managing undifferentiated conditions need to adopt a fail-safe approach, including regular review of the presentation, while 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. Being clear about decisions and referring to evidence during the history taking, examination and investigations helps to 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 can help to clarify and strengthen decision-making.

Communication skills are critical to characterising undifferentiated conditions and to communicating management outcomes to patients. Patients with limited capacity to give complete histories (eg children, patients with dementia, and 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, as well as the potential for carers or guardians to abuse or misuse 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 skill of general practice. Communication skills are the key to successful outcomes in managing undifferentiated conditions of a psychogenic origin.

CS2.2.10.1b ***Management plans that support the early identification of evolving conditions*** – may include ensuring that differential diagnoses are stratified in regards to risk. This can mean creating a list of differential diagnoses and prioritising them in order of conditions which are most likely and most important to exclude due to their potential severity, down to those which are least likely and at least risk of causing harm to the individual. Creating such a list will ideally support the practitioner in creating a safe management plan.

Creation of this list should be followed by consideration of referral for appropriate tests and procedures or specialist opinion, which are those that are likely to be of the most benefit to the health and wellbeing of the individual. Recommendations for such referrals should consider the balance between potential benefits, taking into account the evidence basis, the possible risks and costs, and the sociocultural beliefs of the individual.

CS2.2.10.2b ***Key mental health diagnoses that may present as, or compound, undifferentiated condition presentations*** – may include anxiety (generalised anxiety and obsessive compulsive disorders) and depressive symptoms, somatoform disorders, psychotic disorders, complex PTSD, substance-use disorders etc. Other psychological contributing factors may include fear related to past experiences of the individual or close family or friends, obsessional thinking or anxiety related to concomitant mental health diagnosis, thinking pertinent to the individual's personality type or disorder, etc.

CS2.2.10.3b ***Key sociocultural factors that may present as, or compound, undifferentiated conditions presentations*** – influences that can impact an individual's behaviour, perspective and choices. These influences can include:

- personality type
- mental health diagnoses (eg anxiety and depressive symptoms)
- race
- ethnicity
- gender
- religion
- social class

- family traditions
- peer groups
- age.

CS2.3.1 ***Evidence-based resources*** – may include easy access to, and utilisation, of current paper-based or web-based guidelines, as well as other resources regarding diagnosis, management or social determinants that impact health. Please refer to the Population, presentation and process contextual units for detailed information regarding resource and guidelines for specific population groups, presentations and general practice processes.

CS2.3.1.1a ***Evidence-based medicine*** – may be described as a process of lifelong learning in which caring for patients creates a need for 'the integration of best research evidence with clinical expertise and patient values'.

CS2.3.1.2a ***Useful and relevant resources to refer to when assessing patients*** – evidence-based resources, listed in order of quality of evidence (from least to most significant), include:

- research papers (such as randomised controlled trials, qualitative studies and cohort studies)
- evidence-based guidelines
- evidence summaries
- abstracts, systematic reviews and meta-analyses (eg those found on the Cochrane database) which support practitioners to make clinical decisions when this information is integrated with clinical expertise and individual context.

CS2.3.1.3a ***Skills in critical appraisal of resources*** – refers to the systematic process by which practitioners assess the relevance and validity of research to a particular individual or condition. Practitioners should take a number of factors into account, including:

- the design and type of research or analysis, and thus the levels of evidence for the findings
- whether the study design addressed potential sources of bias, confounding factors and/or conflicts of interest
- whether the data analyses were correct
- whether the data justified the conclusions drawn.

Prior to applying the conclusions of the research to clinical practice, the similarities and differences of the patient population studied need to be compared with the individuals to whom the practitioner wishes to apply the findings.

CS2.3.1.4a ***Research evidence to individual patients*** – may include interactions with patients who have health beliefs which are not based in a Western biomedical context, or who have a low level of health literacy due to sociocultural factors.

CS2.3.1.3b ***Various levels of evidence*** –refers to each study design being assessed according to its place in the research hierarchy. The hierarchy reflects the potential of each study design to adequately answer a particular research question, based on the probability that its design has minimised the impact of bias on the results. For example, a common hierarchy used by the National Health and Medical Research Council (NHMRC) may be Level 1 systematic reviews of Level 2 studies; Level 2 randomised controlled trials; Level 3 non-randomised experimental trials, cohort studies, case-control studies; Level 3 comparative studies without concurrent controls; Level 4 case series.

Clinical guidelines are often the most applicable and useful to GPs, provided that they are current and have been developed through a rigorous process (eg such as those by the NHMRC).[6]

CS2.3.1.5b ***Factors important in determining validity and relevance of research to an individual patient*** – includes assessing:

- whether the relevant research was done in a comparable population group to the patient
- age
- ethnicity
- presence of comorbidities or complications (eg renal or hepatic impairment)

- cognitive impairment (which may increase risk of side effects if medication is not taken correctly)
- concomitant use of other medications with risk of interactions.

CS2.3.2 ***Innovative approach to care of patients with multisystem and/or complex health issues*** – examples of such health issues include:

- endocrine conditions such as type 2 diabetes with vascular or neurological complications,
- rheumatological conditions such as rheumatoid arthritis and systemic lupus erythematosus,
- immunosuppressive conditions such as HIV
- older patients with multimorbidity such as mental health comorbidities in the context of physical illness
- patients with complex PTSD.

Other complexities include the approach to vulnerable individuals for whom negative social determinants of health (such as poor access to employment and education opportunities, adequate and safe housing), may complicate identification, ability to prioritise and management of chronic health problems (eg individuals who are homeless, refugees and asylum seekers, individuals with disabilities, individuals with addiction issues or who have been exposed to family violence).

Innovative approaches may include the development and maintenance of knowledge of eHealth developments (eg utilisation of the PCEHR to improve continuity of care and communication with other health professionals, and therapeutic mental health tools to optimise outcomes for patients), involvement in or awareness of clinical research which may be relevant to patients, ability to be flexible to accommodate patient needs and belief systems when managing patients with multisystem and/or complex medical and/or social conditions.

CS2.3.2.1a ***Opportunities for innovation in general practice*** – may include:

- participation in general practice research
- eHealth tools (eg health tracking tools to monitor weight, steps, dietary intake, blood glucose readings)
- utilisation of and contribution to the PCEHR
- collaboration with community health resources to deliver more efficient and better quality care
- considering different models of care to suit the needs of vulnerable groups in the local community (eg outreach adolescent health clinics in rural and remote communities, mobile screening and/or vaccination clinics in workplaces).

CS2.3.2.2a ***Harm minimisation and therapeutic intervention programs*** – may include identifying patients who demonstrate signs of drug addiction and utilising brief intervention techniques through effective communication and motivational counselling to establish a collaborative therapeutic relationship and minimise risk of harm to the individual. Initial acknowledgement that drug addiction is a treatable disease is an important step and attempting to gain an understanding of the psycho-sociocultural contributing factors to the addiction. Throughout this process, it is important to identify mutual goals to minimise the risk of harm from use of these substances and develop a management plan (eg providing education around safe injecting techniques for patients who use intravenous drugs).

Therapeutic intervention programs include behavioural treatments and/or prescribing medications to enable cessation or reduction in use of addictive substances (eg prescribing methadone, naltrexone or buprenorphine for opiate addiction); use of naltrexone, acamprosate and disulfirim in individuals who are alcohol-dependant; benzodiazepine withdrawal regimens using diazepam, etc.

CS2.3.2.1b ***Strategies to manage clinical scenarios where evidence is lacking*** – may include the use of off-label prescribing (refer to CS2.2.9.2b), or situations such as being advised by a patient that they are using a complementary therapy for which the GP has little information in combination with a conventional therapy. In this scenario, it is important to be non-judgemental, listen to the reasons why the individual is choosing to use this therapy, and seek out reliable resources (refer to Integrative medicine contextual unit IM16) in order to obtain evidence for use and risk of potential interactions or side effects. This will enable adequate counselling and informed consent by the individual to continue or to cease therapy. In counselling patients about use of integrative

or conventional therapies for which there is little evidence, it is important to balance the potential benefits and risks in a non-judgemental and empathic way, which will enable them to make an informed choice while maintaining the therapeutic relationship. Utilising effective communication is imperative to optimise chances of the individual returning to continue care (refer to CS2.2.9.6b).

CS2.3.2.2b ***Innovation to address obstacles to delivering quality care in the community*** – may include addressing time pressures of practice by delivering group education or therapy to individuals with similar health concerns, and addressing vulnerable groups' obstacles in accessing to care by offering screening in the community (eg workplaces, community centres, sporting facilities, etc).

CS2.4.1.1a ***Variety of models of care*** – includes:

- care
- cure
- rehabilitation
- palliation
- health promotion and prevention
- delivery of care to vulnerable communities (eg Aboriginal and Torres Strait Islander peoples, refugees and asylum seekers, groups in custodial settings, homeless people)
- specialised general practice (eg sports medicine, military medicine, sexual health)
- options for models of care in regards to specific populations (eg obstetric care and delivery, including birth centres versus labour wards and GP versus specialist care).

CS2.4.1.1b ***Care versus cure management*** – includes situations where an option for palliation versus active treatment may be chosen by patients with, for example, advanced cancer; severe ischaemic heart disease (eg elderly patient with significant other comorbidities who may opt to decline surgical intervention); an incurable chronic condition (eg COPD, Alzheimer's disease); and schizophrenia.

These patients may utilise therapies and lifestyle interventions which may improve quality of life, reduce risk of complications and prolong life.

CS2.4.1.2a ***Role of general practice in coordination of quality patient care*** – acknowledges the important role that the GP can play in being the professional who takes responsibility for the quality of care provided to an individual. This can be achieved by:

- making appropriate referrals
- following up to ensure the individual attended specialist or allied health appointments and that they understand the diagnosis, investigations or management recommended
- assisting with extra education and support to improve compliance and health outcomes
- utilising recalls to ensure the individual is up-to-date with screening and every aspect of their health needs is being met.

CS2.4.2 ***Fragmentation of care is minimised*** – acknowledges the importance of providing holistic patient-centred care to efficiently identify and manage acute and chronic conditions, and to deliver preventive care and provide health education. This care is often best delivered by a GP who has a good therapeutic relationship with an individual, including an in-depth understanding of their psychosocial context. The capacity to organise appropriate referrals for allied health and specialist care is an important role for GPs; however, this needs to be done efficiently utilising quality communication to minimise the risk of unnecessary repetition of investigations or therapies which can be burdensome to patients and the broader community.

CS 2.4.2.1a ***Roles of health professionals involved in a care team*** – clarification of roles is an important way to minimise fragmentation and reduce risks, as well as unnecessary duplication of care. A care team typically consists of professionals from different disciplines within healthcare who bring different skills and expertise to optimise patient outcomes. The types of professionals required in a care team for a particular patient depends on the

individual's acute and chronic health needs and risk factors, as well as their social context. Important and common members of a care team may include a practice nurse, allied health professionals (eg physiotherapists, dentists, podiatrists, optometrists, exercise physiologists, psychologists, etc), social workers, residential healthcare staff, audiologists and specialists (eg endocrinologists, renal physicians, opthalmologists, oncologists, surgeons, etc).

CS2.4.2.2a *Efficient strategies for effective communication* – may include ensuring the care team is kept up-to-date with relevant information regarding an individual's health status and therapies, and is cognisant of the patient's needs and wishes. This is central to the delivery of quality collaborative care through the provision of concise and relevant patient information, whether written (ie quality referral letters) or verbally (ie during case conferences).

Effective communication can also be achieved via the use of eHealth strategies, such as:

- video conferencing
- internet telephone services (eg Skype)
- email
- SMS
- web services and e-care planning tools
- electronic referrals systems (with use of appropriate encryption)
- electronic prescribing
- electronic patient health records (including PCEHR)
- electronic communication with Medicare, pathology and medical imaging providers
- electronic or tele-based recall systems.

CS2.4.2.3a *Benefit from multidisciplinary care* – includes recognition of the GP's skill set and the complementary skills that other clinic staff (particularly practice nurses), specialists and allied health professionals may provide to optimise quality of care and improve outcomes. This is particularly important for individuals with complex, chronic health conditions who have psychosocial risk factors such as unstable accommodation, addiction issues, problems with medication compliance, etc.

CS2.4.2.4a *Key factors to consider prior to making a referral* – include being clear as to the purpose of the referral (eg opinion on diagnosis or management, request for therapy), whether the professional to whom the patient is being referred has appropriate skills to meet the individual's needs, whether there are other patient needs to consider (eg a request for gender-concordant care), and consideration of cost to the individual, as well as timeliness of appointment, to ensure there is minimal risk of deterioration due to long wait times. Requesting feedback, or involvement in case conferencing or a care plan, can also encourage quality collaborative care.

It is also for important for GPs to understand that they may have an important role to play in providing health information to individuals who request referrals. This can ensure these patients have a good understanding of the potential risks posed by undergoing procedures prior to their specialist appointment which, in turn helps to enable informed consent. A good example of this situation is providing appropriate information prior to the provision of referrals for women requesting cosmetic procedures, particularly genital cosmetic surgery, where the potential risks may not have been made clear by the specialist to whom you have referred (as they may have a pecuniary interest in the individual proceeding with surgery even if this is not clinically indicated).[7]

CS2.4.2.5a *Key local and national organisations or individuals* – may include health professionals and organisations to whom individuals are referred for specialised investigation and management, individuals and organisations (private and government-funded) who provide support and act as resources regarding public health matters or a particular diagnosis or vulnerable group.

CS2.4.2.6a *Timely and high-quality referral letters* – identifies the important role GPs play in facilitation of access to optimal specialist and allied health care at an appropriate level and in a timely and cost-effective fashion with an aim to optimise health outcomes. This acknowledges the context of the economic impacts of unnecessary or inappropriate use of government-funded services which do not positively affect health outcomes. Referral letters

should contain adequate information to accurately identify the patient, including a National E-Health Transition Authority (NEHTA) unique patient identifier if available, and sufficient information to assist the allied health or specialist professional to provide quality care (eg clear reason for the referral, current and relevant past history, family history, medication list, allergies, vaccination status, need for an interpreter, etc). It is also important to maintain confidentiality and not disclose sensitive information which is not relevant to the referral. Referrals sent electronically must be encrypted and the practice must comply with standards for secure transmission of health information.

CS2.4.2.7a *Appropriate follow-up and handover plans* – may include ensuring patients at risk of deterioration, and who require follow-up of investigations or progress with management, are appropriately handed over if their primary GP is going to be away from the clinic. Utilisation of recall systems to remind GPs when patients are due for review or screening can be useful. The development of strategies to ensure that investigation results and specialist letters are regularly reviewed and appropriately acted upon is a key area in provision of quality care.

CS2.4.2.1b *Criteria used to determine if a referral is appropriate* – may include:

- being clear on the purpose of the referral
- ensuring the professional to whom the individual is being referred has the appropriate skills and meets the needs of the patient (particularly regarding gender-concordant care, if requested)
- ensuring the individual is aware of potential costs and wait times
- ensuring an appropriate work-up has been completed and the results are included in the referral letter where appropriate (eg recent liver function tests and other screening results for an individual with hepatitis B being referred to a liver clinic).

It is also important that the GP provides the patient with information about elective procedures where there may be risks associated, and to ensure the patient understands this information, in order to enable informed consent. This is particularly pertinent for cosmetic procedures.[7]

CS2.4.2.3b *Most effective mode of handover* – may include verbal or written.

CS2.4.2.4b *Barriers to effective communication with other health professionals* – may include difficulties communicating during consulting hours, delays in creating and handing over documentation (eg referral letters and discharge summaries), incomplete or difficult-to-read documentation as a result of time pressures or inadequate medical record systems, etc.

CS2.4.2.4c *Conflict within a care team* – may include conflicting opinions about management of an individual, personality conflicts or bullying. Such conflicts can have adverse effects on morale and productivity.

An effective strategy to minimise conflict includes recognising and addressing signs that there are dysfunctional interactions within a team, avoiding judgement or blame and behaving empathically to all members of the team. Identifying situations where individuals may be breaching their professional code of ethics in how they interact with others is an important part of this process. In some situations, an external mediator may be required to facilitate an individual to take responsibility for their behaviour, to resolve the source of conflict and to implement strategies to minimise risks in the future.[8]

CS2.4.3 *Leadership in emergency situations* – includes coordination of emergency situations (eg an individual with a life-threatening illness such as a cardiac arrest, anaphylaxis, collapse or airway obstruction, or a mass casualty event such as a multi-person road trauma, bushfire, chemical spill, etc) whereby tasks are delegated to appropriately skilled individuals (eg the practice nurse or other GPs), effective triaging occurs, safety of healthcare providers and bystanders is made paramount, and effective communication with emergency and other specialised services occurs, etc. An effective response in emergency situations may be enhanced in settings where these occur frequently, with the running of regular practice drills so staff are familiar with where emergency equipment is situated, which staff member is allocated to which role in the team, etc.

CS2.4.3.1a *Teamwork in emergency situations* – refers to the importance of having the most appropriately skilled individual responsible for coordinating the event (may be a GP or the practice nurse), and delegating appropriate tasks to individuals who carry these out and work effectively with other members of the team to optimise outcomes for the affected individual(s). Effective communication is paramount in such situations.

CS2.4.3.2a *Appropriate time to withdraw treatment* – these vary significantly between patients and the reasons for their critical condition. If an individual has a detailed advanced care plan, this can help by providing clear criteria for discontinuation of treatment in the case of a critical event. In a situation where there is evidence that persisting with life support measures is futile, there are established decision-making principles regarding discontinuing life support measures. These generally include acknowledgement that all decisions must be based on respect for life and the patient's right to choose (or the patient's next of kin if this is not possible and not documented in an advanced care plan), and must meet the standards of good professional and ethical practice. All efforts, with transparency and accountability for all decision-making, must be made to obtain the appropriate consent.

Criteria to establish irreversible loss of function of the individual's brain include the presence of a Glasgow Coma Scale score of three, combined with absence of brainstem reflexes, and no spontaneous respirations in the absence of hypothermia, or other situations such as the use of anaesthetic agents.[9,10]

CS2.4.3.1b *Potential risks to the safety of others in an emergency situation* – refer to hazards such as those found at the site of road traumas (eg fuel leakage with the risk of fire, fallen power lines, risk of contamination from blood and body fluids requiring use of appropriate precautions, risks from natural hazards such as bushfires, chemical spills, etc).

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Domain 3. Population health and the context of general practice

'I believe that the basic attribute of mankind is to look after each other' – Fred Hollows

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
CS3.1 GPs make rational decisions based on the current and future health needs of the community and the Australian healthcare system	**CS3.1.1** The *patterns and prevalence of disease* are incorporated into screening and management practices	**CS3.1.1.1a** Undertake early identification of *modifiable risk factors through screening of individuals and their relatives at risk of common diseases*	**CS3.1.1.1b** Implement *screening and prevention strategies* to improve outcomes for individuals at risk of common causes of morbidity and mortality	**CS3.1.1.1c** Analyse effectiveness of vulnerable population-based screening and preventive strategies among the local population
		CS3.1.1.2a Identify the risk factors that define groups vulnerable to common causes of national morbidity and mortality	**CS3.1.1.2b** Incorporate national population-based screening recommendations into individual care	
		CS3.1.1.3a Identify *environmental influences* on health and individuals at risk	**CS3.1.1.3b** Utilise motivational counselling to address *modifiable risk factors in vulnerable groups*	
			CS3.1.1.4b Identify and manage individuals vulnerable to *environmental risk factors*	
	CS3.1.2 The impacts of the *social determinants of health* are identified and addressed	**CS3.1.2.1a** Identify sociocultural factors that can negatively impact on health	**CS3.1.2.1b** Evaluate the impact of *systemic and societal dysfunction* on individuals and propose management plans to reduce risks	**CS3.1.2.1c** Analyse impacts of systemic, societal and familial dysfunction on the local population
		CS3.1.2.2a Evaluate the role, benefits and difficulties of *public health epidemiology in provision of care to individuals*	**CS3.1.2.2b** Identify and address cause and impacts of *familial dysfunction* on individuals	**CS3.1.2.2c** Advocate for change to improve health
	CS3.1.3 Current and emerging *public health risks* are effectively managed	**CS3.1.3.1a** Outline *public health roles relevant to general practice*	**CS3.1.3.1b** Integrate important public health considerations into clinical practice	**CS3.1.3.1c** Mentor and support colleagues to consider public health perspectives and responsibilities in clinical practice
		CS3.1.3.2a Describe public health risks and issues that are addressed by GPs	**CS3.1.3.2b** Describe *criteria for appropriate use of medical isolation*	**CS3.1.3.2c** Initiate public health programs and activities in the community

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
			CS3.1.3.3b Utilise *resources to assist in management of communicable disease outbreaks*	**CS3.1.3.3c** Provide community education related to culturally specific practices that may impact health
			CS3.1.3.4b Notify public health risks and concerns according to *relevant legislation and regulations*	
			CS3.1.3.5b Participate in *public health initiatives* in the community	
CS3.2 GPs effectively *lead to address the unique health needs of the community*	**CS3.2.1** *Barriers to equitable access to quality care* are addressed	**CS3.2.1.1a** Identify vulnerable groups within the local community and barriers they may have to healthcare access	**CS3.2.1.1b** Develop strategies to improve access to general and *preventive care for vulnerable groups*	**CS3.2.1.1c** Assess practice demographics to determine whether the needs of vulnerable groups are being met
		CS3.2.1.2a Detail *community sociocultural factors that may impact on health presentations and outcomes*		**CS3.2.1.2c** Maintain up-to-date practice information on Medicare benefits to inform colleagues and patients
	CS3.2.2 The health needs of individuals are balanced with the health needs of the community through effective *utilisation of resources*	**CS3.2.2.1a** Outline the roles of the Medicare Benefits Schedule (MBS) and PBS	**CS3.2.2.1b** Appraise and review Medicare billings to ensure compliance with guidelines	
			CS3.2.2.2b Review use of the PBS to ensure compliance	
			CS3.2.2.3b Appropriately access *Australian Government funded programs* for vulnerable groups	
	CS3.2.3 Effective leadership improves outcomes for patients	**CS3.2.3.1a** Define *types of general practice leadership*	**CS3.2.3.1b** Identify *opportunities and obstacles to effective leadership* in general practice	**CS3.2.3.1c** Mentor colleagues to take on leadership roles
		CS3.2.3.2a Define the qualities of *effective leadership* in general practice	**CS3.2.3.2b** Advocate for vulnerable individuals or groups within the community	

Context and application: Domain 3

CS3.1 ***Australian healthcare system*** – may be described as a complex network of public and private services constructed to promote, restore and maintain the health of the population through provision of cost-effective, quality healthcare. The components of the system include:

- primary healthcare, which is provided by Aboriginal and community controlled health services; GPs and nurses, dentists and allied health professionals in private or community health centres, the PBS which enables subsidised access to some medications, and the MBS which enables subsidised access to some primary, secondary and tertiary care services, investigations and procedures
- secondary care, which is provided by specialists or facilities after referrals have been made by a GP
- tertiary care , which incorporates public and private hospitals and their emergency departments.

Behind this network is a structure of governance and support mechanisms, including the MBS and PBS, the Australian Commission on Safety and Quality in Health Care (ACSQHC), the TGA, and state and territory health and insurance ombudsmen.[1]

CS3.1.1 ***Patterns and prevalence of disease*** – prevalence refers to the number of cases of a disease, and contributing factors, in a particular population at a particular time. Identifying patterns of disease assists in clarifying risk factors, which may include:

- stage of the lifecycle
- geography
- lifestyle (eg smoking, inactivity, nutritional status)
- environment (eg climate change and its consequences, such as extreme weather events and forced migration)
- socioeconomic status
- gender
- race
- genetics
- occupational.

Identification of risk factors assists in appropriately targeting screening to enable early diagnosis and management of particular conditions to improve health outcomes, and to plan for adequate health service provision.

Diseases of population health concern in Australia (priority diseases) include the major causes of morbidity and mortality which affect subgroups of the population with specific risk factors (eg obesity, obstructive sleep apnoea, cerebrovascular and ischaemic heart disease, breast and prostate cancer, osteoarthritis, COPD, asthma, noninsulin-dependent diabetes mellitus [NIDDM], dementia, mental health, etc), as well as those for which the entire population is at risk (eg notifiable communicable diseases, including varicella, measles, meningococcal meningitis, severe acute respiratory syndrome [SARS], etc).

It is also important to identify other trends that impact health, such as substance use (eg methamphetamines, alcohol, marijuana, heroin, e-cigarettes), fertility and unintended pregnancy rates.

CS3.1.1 ***Screening and management practices*** – population-based preventive health strategies are determined largely by disease prevalence and recognition of existent risk factors and vulnerabilities in the local population. For example:

- provision of opportunistic immunisation
- engagement in age-appropriate and risk-appropriate screening (eg well child checks, Pap smears, mammograms, fasting lipids and glucose, blood pressure checks, etc)
- management of lifestyle risk factors (particularly smoking, nutrition, alcohol and physical activity)

- comprehensive travel health consultations
- stress management interventions, etc.

CS3.1.1.1a *Individuals and their relatives at risk of common diseases* – includes:

- identifying individuals at risk due to lifestyle factors
- being of an ethnicity or race which is at risk of certain diseases (eg breast cancer and Ashkenazi Jewish descent, oesophageal cancer in southern Chinese) and genetic predisposition
- recognising families in which genetic transmission of particular disease states is likely (eg haemachromatosis, coeliac disease, Down's syndrome, familial hypercholesterolaemia, Factor V Leiden, haemophilia, polycystic kidney disease, etc).

Identification of individuals at risk also includes screening those at risk of substance use and addiction-related issues, and educating those at risk of occupational injuries regarding the need for immunisation, workplace ergonomic modification, prevention of musculoskeletal and stress-related injuries, etc.

CS3.1.1.1a *Modifiable risk factors* – exposures which increase risk of disease that can be changed through lifestyle modification or commencement of treatment for elevated blood pressure, lipids, to assist with smoking or alcohol cessation, etc. GPs are often well placed to provide advice on lifestyle modification, including:

- exercise regimens
- dietary improvements
- sleep routine
- adequate sun exposure
- involvement in community activities
- stress management techniques
- communication strategies and conflict resolution with significant others
- avoidance of chemicals, pollutants, alcohol, smoking and other addictive substances.

CS3.1.1.3a and 4b *Environmental influences on health* – may include consequences of climate change (eg extreme weather events with heat and cold impacting older patients and infants), impacts of forced migration, increased temperatures leading to introduction of new vector-borne diseases (eg dengue fever, malaria, Ross River fever in historically cooler areas), etc. Geographical position of practice is important in regards to areas at risk of natural disasters (eg flooding, cyclones and bushfires), whereby it is important for GPs in these areas to have disaster management plans in place.

Other influences include impacts of airborne allergens, pollution and occupational exposures (eg asbestos, lead, dust, chemicals, radiation, flammable liquids, gases, etc).

CS3.1.1.1b *Screening and prevention strategies* – includes utilising recall system and flags in patient records for reminders regarding vaccinations, screening, and where appropriate, prophylactic treatment for those at risk, as well as opportunistic screening when risk factors are identified based on established guidelines.

Targeted vaccinations may include pneumococcal vaccine and flu vaccination for individuals aged older than 65, Aboriginal and Torres Strait Islander individuals aged six months to five years and who are older than 15 years, and individuals with chronic diseases that place them at increased risk; hepatitis B vaccination for family members of individuals diagnosed with hepatitis B; and screening of at-risk groups for prevalent diseases.

Targeted screening using evidence-based tools may include:

- the geriatric depression scale and mini–mental state examination (MMSE) in older individuals
- offering women chlamydia polymerase chain reaction (PCR) with Pap smears
- referring for screening for glaucoma or macular degeneration in individuals with a family history

- mental health and substance use screening questions for any individual experiencing stressors.

Utilisation of preventive strategies may include adequate counselling for travellers regarding antimalarials if travelling to high-risk areas, and education regarding avoidance of mosquito bites and traveller's diarrhoea.

CS3.1.1.3b *Modifiable risk factors in vulnerable groups* – vulnerability may be defined by a number of parameters, including ethnic or sociocultural factors which make individuals prone to particular conditions and impact their access to healthcare, and physical vulnerabilities due to illness or life stage. Vulnerable groups may include:

- Aboriginal and Torres Strait Islander peoples
- individuals from CALD communities, particularly refugees and asylum seekers
- lesbian, gay, transgender, bisexual, intersex and queer (LGTBIQ) individuals
- people with low health literacy
- individuals in rural and remote areas
- individuals with severe mental health problems which impact their ability to prioritise their own health (eg schizophrenia, severe depression, complex PTSD)
- war veterans
- emergency service personnel and other occupations at risk of physical and/or psychological injuries related to hazards of their employment
- socially disadvantaged individuals (eg unemployed, homeless, etc)
- individuals with physical and/or intellectual disabilities or impairments
- antepartum, antenatal and postnatal women
- individuals who are using illicit substances (eg individuals who inject and are at risk of blood-borne viruses and bacterial infections)
- adolescents
- individuals detained in correctional facilities or immigration detention.

CS3.1.2 *Social determinants of health* – may be described as, 'the conditions into which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life' which impact health equity.[2] Examples include:

- social inclusion
- connectedness
- meaningful participation (measure of the degree to which individuals or groups are able to access opportunities and resources available to others)
- employment
- functional housing
- access to quality education and early childhood developmental opportunities
- adequate nutrition.

CS3.1.2.2a *Public health epidemiology in provision of care to individuals* – public health epidemiology may be defined as the science of patterns, causes and effects of health and disease conditions in defined populations. This is important knowledge for GPs to maintain in order to enable targeted screening and early management of disease states to improve outcomes. Useful epidemiological skills and concepts include gaining an understanding of:

- incidence and prevalence of common and serious conditions within the Australian population and vulnerable subgroups

- transmission rates
- mortality and morbidity rates
- pandemic versus epidemic versus endemic
- number needed to treat
- odds ratio, relative risk reduction
- relative risk.

It is important to acknowledge knowledge of the priority diseases as the most common contributors to mortality and morbidity, and thus the justification that these are the focus for population-based preventive health strategies. As of 2012, the Australian Institute of Health and Welfare (AIHW) has defined cardiovascular disease, cancer, mental health, diabetes, asthma, dementia, injury, obesity, and arthritis and musculoskeletal conditions as the key national health priorities.[3.]

When delivering patient-centred care, integration of population health knowledge to individuals can add another layer of complexity and time to consultations, and social determinants of health may impact the individual's ability to access screening and preventive care. The GP plays an important role in assisting individuals to negotiate obstacles to access the care they need.

CS3.1.2.1.b ***Systemic and societal dysfunction*** – refers to the importance of identifying social factors which increase the risk of particular diseases to assess whether they can be modified to reduce risks in the future (eg the impacts of poverty in some residential areas, consequent homelessness, crime, illicit substance use, etc).

CS3.1.2.2b ***Familial dysfunction*** – may include situations of family violence, child abuse, substance use, and consequences of poverty and addiction (eg substance and behavioural addiction). Impacts may include physical and psychological trauma (particularly complex PTSD), substance use, involvement in crime, etc.

CS3.1.3 ***Public health risks*** – may include:

- notifiable communicable diseases (eg hepatitis A, giardia, rotavirus, salmonella, etc)
- sexually transmitted infections (eg chlamydia, gonorrhoea, syphilis, human papillomavirus [HPV], etc)
- vector-borne diseases (eg malaria, dengue fever, etc)
- airborne viruses (influenza, tuberculosis, etc)
- vaccine-preventable diseases (eg hepatitis B, measles, mumps, varicella, tetanus, polio, meningococcus, haemophilus, etc)
- blood-borne viruses (eg HIV, hepatitis C, etc)
- infections spread by contact (eg chlamydial eye infections)
- potential environmental hazards (eg water quality, respiratory effects of pollution, etc)
- occupational-related hazards (eg asbestos exposure).

CS3.1.3.1a ***Public health roles relevant to general practice*** – may include:

- making notifications to the state or territory Department of Health and assisting with contact-tracing once informed consent has been provided regarding sexually transmitted infections
- communicable diseases (eg active pulmonary tuberculosis)
- implementing vaccination programs with appropriate education (and typically in a team with practice nurse/s)
- identifying health concerns in the local community (eg related to occupational or environmental risk factors) and managing these through advocacy and professional support
- staying informed of disease trends and guidelines regarding screening and prevention to assist in identifying vulnerable groups, and detecting or preventing disease to improve health outcomes.

CS3.1.3.2b *Criteria for appropriate use of medical isolation* – may include suspicion of an individual demonstrating signs of infection due to an airborne or droplet-spread pathogen which is a communicable notifiable condition (eg measles, varicella, influenza, etc) whose presence in a public area of the clinic may pose risks to others. This is particularly relevant in the case of individuals who may be immunocompromised (eg young children, pregnant women, older individuals or those taking immunosuppressants). Efficient identification and management of individuals with readily communicable diseases requires a team approach, particularly involving the practice nurse(s) to assist with efficient triage and empowerment of reception staff to ask simple questions of patients when they attend (assisted with appropriate use of signage) in the setting of disease outbreaks (eg influenza, Ebola, etc).

CS3.1.3.3b *Resources to assist in management of communicable disease outbreaks* – may include:

- effective triaging of febrile patients
- robust use of infection control procedures
- appropriate use of medical isolation
- vaccination of vulnerable members of the population
- use of communicable disease notification framework
- contact-tracing after diagnosis
- effective transmission-minimisation education for patients, family members and/or carers
- efficient communication with hospitals prior to patient transfer.

CS3.1.3.4b *Relevant health legislation and regulations* – refers to the importance of GPs understanding their state or territory requirements for reporting of notifiable conditions and the time limits in which this should occur.

CS3.1.3.5b *Public health initiatives* – may include participation in health education and promotion campaigns, implementation of vaccination programs, advocacy regarding issues of public health concern, etc.

CS3.1.3.3c *Culturally-specific practice which may impact health* – may include female genital mutilation, circumcision, forced marriage, etc.

CS3.2 *Effectively lead* – relates to the important role of the GP in addressing stigma and advocating for the rights of patients within the community, with health organisations and institutions, with the government and, if appropriate, in the media. Examples of issues that may require leadership include improving public awareness and reducing stigma about mental health issues, advocating for vulnerable individuals or groups (eg cultural minority groups), improving health literacy, etc.

CS3.2 *Address the unique health needs of the community* – refers to the importance of identifying the factors such as age, gender, socioeconomic status, cultural differences, demography of the area, remoteness, and costs of healthcare in prioritisation of health issues and consequent access. An example of a way to address the needs of the community is attention to youth, sexual and gender-diversity-friendly structures (these include physical environment, and attitudes and knowledge of doctors, nurses and other staff members) and consequent strategies to make a practice welcoming to all people.

CS3.2.1 *Barriers to equitable access to quality care* – health services must be available, affordable, physically accessible, acceptable and in adequate supply. Barriers may include low socioeconomic indicators, lack of health literacy, lack of resources or supply, beliefs and social attitudes, language and lengthy waiting times.

CS3.2.2 *Utilisation of resources* – may include:

- the importance of mindfulness of the economic costs of each consultation to the state or territory
- a referral made and prescription written as a check to ensure these are provided based on evidence and equity
- the need for compliance with MBS and PBS requirements
- utilisation of telehealth resources (eg tele-dermatology to access specialist services efficiently), etc.

CS3.2.2.1a *MBS and PBS* – provide Australian Government funds to fully or partially subsidise access to primary, allied and specialist healthcare, and to the range of medications which are listed in the schedule. The availability of these benefits contributes to improving equitable access to care and treatment for the Australian population.

CS3.2.2.3b *Australian Government-funded programs* – examples include:

- chronic disease management plans for individuals on low incomes to enable access to allied health services
- Aboriginal and Torres Strait Islander health assessments
- mental health plans for individuals on low incomes to enable access to clinical psychologists or counsellors (DoH Better Access initiatives)
- health assessments for individuals aged 75 and older
- refugee health assessments
- utilisation of TIS
- mental health nurse incentive program.

CS3.2.3.1a *Types of general practice leadership* – Effective general practice leadership can take a number of forms. Many GPs struggle to define themselves as leaders; however, a GP who takes a central role in the coordination of patient care with external health professionals in the community, using a holistic, patient-centred approach, effective communication, vision-setting and a strategic approach to advocate for individual patients when there are issues with equitable access, can be said to be demonstrating a form of leadership. Other forms of leadership include:

- medical educators who enhance quality of care through inspiring and setting the vision for future GPs
- practice owners who provide inspiration, a clear vision and direction for their staff to create a collegiate, functional and innovative service – an important part of this is creating a team, which is not hierarchial, which uses respectful communication and acknowledgement of the skills and experience of each of its members to optimise care and a healthy work environment
- clinical leaders who create better patient outcomes by improving healthcare provision through quality and safety developments, at both the macro and micro levels
- GPs who participate in advocacy regarding issues pertinent to the health of the population and/or vulnerable groups within the community, identifying a need and demonstrating skills in increasing awareness and initiating change in relation to those needs
- academic GPs who drive research into important areas, impacting health or general practice service provision.

CS3.2.3.2a *Qualities of effective leadership in general practice* – involves a combination of skills, which may include:

- knowledge about a particular issue, organisation, value or goal
- demonstrating confidence and a capacity for self-reflection of strengths and weaknesses, and creating a team which complements these abilities, to achieve a common goal
- use of clear, motivational and respectful communication which facilitates a supportive and collegiate environment and inspires action
- vision and goal-setting, as well as the ability to clearly communicate these ideas
- ability to take measured risks
- being perceptive and respectful of team members' feedback
- ability to demonstrate empathy and flexibility when obstacles are faced
- having integrity.

CS3.2.3.1b *Opportunities and obstacles to effective leadership* – having a broad base of knowledge and professional networks, the experienced GP is well suited to taking on leadership roles. Involvement in committees

and advisory groups can be a valuable way to gain experience to further interests in advocacy and other forms of leadership in the future. Obstacles may be overcome by strategies such as accessing mentoring to enable individuals to have the confidence and develop the skills to fulfil these roles adequately, accessing support with media training, and seeking further education in areas of interest (eg medical administration, small business management, etc).

References

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2. World Health Organization. Social determinants of health. Available at www.who.int/social_determinants/en [Accessed 9 December 2015].
3. Australian Institute of Health and Welfare. National health priority areas. Available at www.aihw.gov.au/national-health-priority-areas [Accessed 9 December 2015].

Domain 4. Professional and ethical role

'It takes less time to do things right than to explain why you did it wrong' – Henry Wadsworth Longfellow

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
CS4.1 GPs are ethical and professional	**CS4.1.1** Adherence to *relevant codes and standards of ethical and professional behaviour*	**CS4.1.1.1a** Identify key features of professional codes of ethics and conduct relevant to clinical practice	**CS4.1.1.1b** Identify *ethical dilemmas* in practice situations	**CS4.1.1.1c** Regularly reflect on professionalism and ethical conduct
		CS4.1.1.2a Distinguish the *impact of the power differential in the therapeutic relationship*	**CS4.1.1.2b** Access *professional resources to obtain support for ethical dilemmas*	**CS4.1.1.2c** Implement changes and quality improvements based on reflections
			CS4.1.1.3b Evaluate and review professional behaviour against appropriate codes of conduct	**CS4.1.1.3c** Mentor and support colleagues to access and adhere to professional codes of conduct
			CS4.1.1.4b Identify and manage *areas of disparity between behaviour and codes of conduct*	
	CS4.1.2 *Duty of care* is maintained	**CS4.1.2.1a** Define duty of care	**CS4.1.2.1b** Identify and manage clinical situations where there are obstacles to provision of duty of care	**CS4.1.2.1c** Facilitate and support colleagues in adhering to duty of care responsibilities
		CS4.1.2.2a Identify potential *obstacles to duty of care*	**CS4.1.2.2b** Record and report any *instances where duty of care may have been compromised*	**CS4.1.2.2c** Review and revise policies and procedures relating to duty of care in the practice
		CS4.1.2.3a Identify duty of care responsibilities in different clinical scenarios		
	CS4.1.4 *Critical incidents and potential critical incidents* are identified and managed	**CS4.1.4.1a** Identify potential and actual critical incidents and propose strategies to review and improve quality of care as a result	**CS4.1.4.1b** Implement strategies to review potential and actual *critical incidents to manage consequences and reduce future risk*	**CS4.1.4.1c** Facilitate *debriefing and support for colleagues following critical incidents*
		CS4.1.4.2a Identify the need to debrief and obtain support after critical incidents		**CS4.1.4.2c** Document critical incidents to use for further quality improvement and reporting

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
CS4.2 GPs are self-aware	**CS4.2.1** Professional knowledge and skills are reviewed and developed	**CS4.2.1.1a** Identify knowledge and skills gaps, and *plan meaningful learning* to address them	**CS4.2.1.1b** *Formulate strategies* to identify and address learning needs	**CS4.2.1.1c** Identify and address learning and skill development needs through *ongoing professional development*
		CS4.2.1.2a Implement and review planned learning	**CS4.2.1.2b** Appraise and review response to constructive feedback	**CS4.2.1.2c** Actively engage with *professional bodies in special interest areas*
			CS4.2.1.3b Identify and utilise *professional resources that may assist in quality care provision*	
			CS4.2.1.4b Outline factors that create an effective *learning environment*	
	CS4.2.2 *Reflection and self-appraisal* are undertaken regularly	**CS4.2.2.1a** Identify *personal factors* that may impact therapeutic relationships and delivery of care	**CS4.2.2.1b** Implement *strategies to recognise and manage personal factors* if they impact on quality of care or personal wellbeing	**CS4.2.2.1c** Mentor and support colleagues to implement reflective practice and self-appraisal
			CS4.2.2.2b Reflect on and review personal and professional performance with supervisors and other professionals	**CS4.2.2.2c** Engage in reflective practice
				CS4.2.2.3c Identify and address *potential conflict that may occur if a variety of professional roles are held*
	CS4.2.3 *Personal health and wellbeing* is evaluated, maintained and developed	**CS4.2.3.1a** Evaluate personal wellbeing regularly and identify health issues that create risk and may impact quality of care	**CS4.2.3.1b** Identify and manage personal health issues by accessing professional support as needed	**CS4.2.3.1c** Identify and address barriers to maintaining health and wellbeing

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
		CS4.2.3.2a Distinguish importance of medical professionals accessing healthcare when needed	**CS4.2.3.2b** Identify need and access *support for emotional reactions to confronting clinical situations*	**CS4.2.3.2c** Develop an occupational environment that promotes personal and professional wellbeing
		CS4.2.3.3a Devise *structures to support personal health and wellbeing*	**CS4.2.3.3b** Identify and manage *occupational health risks* of GPs	**CS4.2.3.3c** Mentor and develop *skills in debriefing colleagues* after distressing experiences
			CS4.2.3.4b Identify mentors to support personal and professional development	
CS4.3 GPs mentor, teach and research to improve quality care	**CS4.3.1** Professional knowledge and skills are effectively shared with others	**CS4.3.1.1a** Identify and respond to the personal learning needs of others	**CS4.3.1.1b** Develop strategies to share recently acquired skills and knowledge with peers	**CS4.3.1.1c** Maintain *appropriate role boundaries*, and manage time constraints to mentor and support colleagues to improve knowledge and skills
		CS4.3.1.2a Encourage and support peer discussion and clinical questioning	**CS4.3.1.2b** Assist peers and colleagues to identify and prioritise areas of clinical knowledge and skill that are in need of development	**CS4.3.1.2c** *Teach effectively and accountably* by utilising communication and leadership skills
		CS4.3.1.3a Describe resources accessed to assist with knowledge and skill development of peers and junior colleagues	**CS4.3.1.3b** Identify strategies to create an *inclusive team-based approach to teaching and leadership*	**CS4.3.1.3c** Identify *safety net strategies* to enable clinical exposure and minimise risks to patients from inexperienced colleagues
		CS4.3.1.4a Identify clinical knowledge gaps that would be suitable for general practice research	**CS4.3.1.4b** Contribute to and utilise *best practice guidelines in general practice research*	**CS4.3.1.4c** Optimise teaching skills through networking and ongoing development
				CS4.3.1.5c Implement *procedures to ensure research complies with relevant guidelines*

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
				CS4.3.1.6c Lead or participate in general practice research
	CS4.3.2 Identify and support *colleagues who may be in difficulty*	**CS4.3.2.1a** Identify *professional resources that are available to assist health professionals who are in difficulty*	**CS4.3.2.1b** Identify, support and appropriately refer colleagues who are in difficulty	**CS4.3.2.1c** Develop and disseminate procedures and information relating to doctors or other health professionals in difficulty
			CS4.3.2.2b Formulate strategies to maintain duty of care if a colleague displays limited insight into reduced capacity to practice	**CS4.3.2.2c** Identify and support colleagues who may be vulnerable

Context and application: Domain 4

CS4.1.1 *Relevant codes and standards of ethical and professional behaviour* – includes resources which can assist health professionals by defining acceptable conduct and practice in relation to their peers, in working with professional values and ethics primarily by making the care of the patient the primary concern, and in practising medicine safely. Examples of professional codes and standards include:

- Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*[1]
- RACGP's *Standards for general practices*[2], clinical[3] and practice management policies[4]
- Australian Medical Association's (AMA) *Code of ethics*[5]
- Medicines Australia's *Code of Conduct*[6]
- NHMRC's *National statement on ethical conduct in human research*[7]

CS4.1.1.2a *Impact of power differential in the therapeutic relationship* – it is important to recognise that there exists a power differential between the GP and the patient in many consultations. This difference can be minimised through the development of an effective, respectful therapeutic relationship and good communication; however, it often still exists. This difference arises as a consequence of many factors, including:

- sociocultural backgrounds and cultural lens
- previous experiences
- personality types of patient and doctor
- health beliefs
- the perceived degree of patient dependence on the GP to receive the type of care they require.

This power difference is particularly pertinent when patients are asked about participation in research and quality improvement activities. In this situation, it is important to acknowledge this difference and its potential effects on the patient's capacity to provide informed consent and feel comfortable in declining the invitation without concerns about their care being impacted as a result.

CS4.1.1.1b *Ethical dilemmas* – may arise when there are apparent contradictions between the elements of a GP's ethical code and that of the patient broader society. Some examples include:

- in the context of care of people with disabilities, where dilemmas may arise around complex instances (eg potential conflict between competent medical care, patient autonomy, inherent concepts of 'social worth' and universal human dignity, etc)
- in the realm of antenatal screening and/or the decision to continue or to terminate pregnancies for genetic abnormalities or bodily impairments
- in more routine provision of individual care (eg sexual wellbeing, definition of 'troublesome behaviours', decisions regarding degree of carer and family involvement for individuals who have questions over their capacity to provide consent, in the disparity between public and private health policies and access to care, etc)
- where a patient refuses to inform family members who are at risk when a diagnosis is made (eg a communicable disease) which causes duty of care issues to predominate.

It is important to consider the significance of ensuring that each professional is aware of their own values and belief systems, and how these may have an impact on patient care when dealing with examples such as those outlined above. If a conflict is recognised, the GP has a duty of care to identify and assess the situation, reflect on their own role, and consider multiple perspectives and options available to facilitate a decision. Resolutions need to be timely for patient care and in line with professional codes of conduct, and individuals are encouraged to seek formal or informal guidance and document their decision-making. Referring patients to other professionals who are able to provide the care they require may be the appropriate course of action in some situations.

CS4.1.2 ***Duty of care*** – refers to the professional's responsibility for the optimal care of patients. Important criteria which assist in defining this responsibility include:

- acting on patient cues
- respecting patient–doctor boundaries
- maintaining confidentiality
- recognising professional limitations in one's self and in colleagues
- ensuring appropriate reporting and follow-up
- undertaking advocacy as appropriate.
- respecting a patient's culture and values, and maintaining an awareness of how these have an impact on the therapeutic relationship
- understanding patients' rights of to access competent, compassionate care, be fully informed, and self-determination.

CS4.1.2.2a ***Obstacles to duty of care*** – may arise in more complex situations where the GP has duty of care to a number of parties involved in a situation (including to the general community) in which there is perceived or actual conflict between these responsibilities. Examples may include:

- situations where contact-tracing is required for communicable diseases, particularly STIs where the patient of the GPs wishes to remain anonymous due to concerns regarding consequences
- identifying and managing expectations of workplace stakeholders, particularly considerations regarding whether to modify patient management to suit employer culture for individuals with occupational injuries (this is especially relevant for elite athletes who are under pressure from coaches and/or sporting organisations to compete despite injuries or illness)
- mandatory reporting to the Department of Human Services' Child Protection, where the alleged perpetrator and child are both patients of the GP (the GP's duty of care to the minor should always take precedence in such a situation)
- situations where an individual may have impaired capacity to provide consent and their carer is also a patient of the GP and there is a conflict in decision-making regarding management
- during reviews for fitness to drive, where the GP is aware that the patient is demonstrating diminished capacity to drive, but would be severely impacted by having their licence revoked
- utilisation of involuntary admission certification for individuals who are putting themselves or others at risk due to experiencing severe mental health issues.

CS4.1.2.2b ***Instances where duty of care may have been compromised*** – refers to situations such as those outlined in CS4.1.2.2a, where a GP believes the decisions around duty of care responsibilities may have been flawed or have been consequently challenged by another party. In situations where there are questions over duty of care, it is important for the reasons for decisions made to be documented, to consider notifying the appropriate medical defence organisation, and to debrief with trusted senior colleagues.

CS4.1.3 ***Patient–doctor boundaries*** – refers to maintaining a separation of personal and professional relationships, particularly where there is a possible imbalance of power in the relationship (eg when a patient's judgement may be impaired), in order to enable maintenance of a therapeutic relationship. Recognition of transference and countertransference is very important to ensure that appropriate boundaries are maintained.

Transference refers to the phenomenon by which individuals 'unconsciously transfer feelings and attitudes from a person or situation in the past on to a person or situation in the present. The process is at least partly inappropriate to the present.' This process is unconscious and can occur in either direction in the patient–doctor relationship. Risk factors for transference include vulnerable (eg complex PTSD, severe depression or anxiety), perceptions of dependence, associated anxiety about physical or psychological safety, and frequency of contact (inside or outside of the clinic).

Countertransference refers to the response elicited in the GP by the patient's transference communications. It is important for GPs to recognise when this is occurring and to address it empathically and respectfully, and to agree with the patient on some clear therapeutic boundaries.

CS4.1.3.2a *Potential consequences of unclear boundaries* – includes the development of unreasonable patient expectations which are unable to be met, and may put the patient at risk or raise the possibility of legal action.

CS4.1.3.1b *Patient interactions where there is a blurring of therapeutic boundaries* – red flags for the risk of inappropriate interactions need to be firstly recognised by the GP and managed (as outlined in CS4.1.3) in order to minimise risks. Examples of such red flags include:

- the GP feeling uncomfortable about seeing a particular patient
- requests from patients for dishonest or unethical behaviour by the GP (eg supplying medications that are not clinically indicated, providing incorrect information on legal documentation, taking part in an intimate relationship, etc)
- situations where the GP may be providing a level of care that is outside of their normal practice.

Patients with complex PTSD are often particularly vulnerable to developing transference with their health providers. While this behaviour is subconscious, it needs to be acknowledged and appropriately managed.

CS4.1.3.2b *Terminating therapeutic relationships where boundaries are not maintained* – in this situation it is important for GPs to consider that they have a duty of care to refer the individual to another GP in order to enable continuity of care. While strategies used to achieve this referral vary according to the situation, it needs to be effectively communicated with empathy and respect.

CS4.1.4 *Critical incidents and potential critical incidents* – to situations which are not necessarily dramatic events, but which carry significance for the health professional and/or the patient. Critical incidents may raise questions about individual or organisational beliefs, behaviours, values or attitudes that create space for reflection, and may prompt change in thinking, policy or behaviour. Critical incidents may be caused by issues related to knowledge, culture, beliefs, emotions, relationships or communication.

Examples of critical incidents may include:

- a missed diagnosis leading to poor clinical outcome
- a communication problem or difficult interaction between a health professional and a patient or family member
- situations which cause individuals to feel inadequate, unsupported or confronted, etc.

CS4.1.4.1b *Critical incidents to manage consequences and reduce future risk* – may include assignment of a senior clinical professional in the practice as the individual who organises debriefing after a potential or actual clinical incident, and educating new staff about how critical incidents are managed.

CS4.1.4.1c *Debriefing and support for colleagues following critical incidents* – may include establishment of formal or informal support for professional peers, development of education in recognising when colleagues are struggling with a specific issue or generally, and provision of information on strategies to assist peers with specific or general issues and options for more intensive assistance. Avoiding blame is an integral part of effective debriefing.

CS4.2 *Self-aware* – may be used in this context to describe a professional's ability to be reflective and develop a clear perception of their own personality, communication style, knowledge base, thoughts, beliefs, possible biases, motivation, values and emotions. This enables insight into how the professional may be perceived by others and how to minimise risks of problems with communication or professional and therapeutic relationship.

CS4.2.1.1a *Plan meaningful learning* – incorporates a normative curriculum that identifies what students should learn, as well as student-centred learning intent (ie what they want to learn, which may be determined through reflective practice), collaboratively developing learning needs, objectives and a plan by which to address them. It is also helpful to plan for regular evaluation and feedback, collection of evidence of learning, and periodic revision of the learning plan prior to submission.

CS4.2.1.1b *Formulate strategies* – reflective practice is a core aspect of learning need identification. This includes developing the capacity to reflect on clinical skills and knowledge in order to engage in a process of continuous learning. As well as paying attention to whether clinical practice is evidence-based and if not, determining whether it is in line with peers, there is justification and rationale behind clinical choices, effective communication is being used, and practice is ethical and professional.

Appropriate supervision of junior medical staff, and regular evaluation of that supervision, takes into account the knowledge and skills of the individual, as well as their capacity for insight into their learning needs. This provides knowledge as to whether the individual is able to identify when supervision is required or whether the supervisor needs to be prescriptive as to the types of consultations and procedures which require supervisor input (eg prescribing of Schedule 8 medications, minor procedures, etc). Safety of the patient must be paramount in this consideration.

Strategies to stimulate learning and encourage reflection may include use of role plays, observation of consultations through sitting in or recording, case presentations of complex cases at practice meetings, critical case discussions, etc.

CS4.2.1.3b *Professional resources that may assist in quality care provision* – easy access to evidence-based resources to assist in provision of quality care is an important aspect of general practice in the context of the broad range of populations and conditions that present for care. A good level of self-awareness and utilisation of reflective practice can assist in recognising when additional resources are required to deliver high-quality care and improved outcomes for patients. Utilisation of critical appraisal skills in determining whether the resources are applicable to a particular patient are another essential skill. Professional resources may include diagnostic and prescribing guidelines, position statements of key national and local health organisations, and other resources outlined in CS2.4.2.5, CS 2.3.1 and CS2.3.1.2.

CS4.2.1.4b *Learning environment* – may include factors such as:

- being accessible as a supervisor and mentor both physically onsite and through a non-judgemental, non-critical and respectful approach to mentoring and teaching – this enables junior staff members to be comfortable in requesting assistance when required
- provision of therapeutic and management guidelines to assist junior staff members
- creating structures to allow time for education opportunities as they arise
- creating structures to enable honest and fair provision of feedback regarding teaching and mentoring in order to maintain quality improvement
- recognising any difficulties which arise for junior staff and providing support, either personally or by recommendation of other external resources externally.

CS4.2.1.1c *Ongoing professional development* – may take many forms and it is important for GPs to identify types of learning from which they benefit most readily. This is partly related to the learning style of the individual and specific learning needs identified. Professional development may include:

- the use of small group learning and journal clubs
- Balint groups
- clinical audit and e-audit tools
- participation in external data extraction/research projects
- active learning modules (ALMs)
- cultural awareness training
- peer reviewing journal articles
- graduate certificate or diploma courses, master's degree.

CS4.2.1.2c *Professional bodies in special interest areas* – may include groups and organisations such as:

- RACGP Aboriginal and Torres Strait Islander Health, RACGP Specific Interests, RACGP Rural
- Australasian Society for HIV Medicine
- International Society of Travel Medicine
- Public Health Association of Australia
- Refugee Health Network of Australia
- Australian Medical Acupuncture College
- Australasian Integrative Medicine Association
- Australian Association of Musculoskeletal Medicine
- Australasian Faculty of Musculoskeletal Medicine
- Sports Medicine Australia
- Sports Doctors Australia
- Australian College Physical Medicine.

CS4.2.2 *Reflection and self-appraisal* – reflective practice is a term that may be used to describe the recognition and evaluation of multiple perspectives in healthcare interactions, including an emphasis on self-awareness and insight. Reflective practice comprises the critical examination of one's self (acknowledging factors such as cultural bias, personal values and beliefs), interpersonal relationships and the health system. Reflective learning is an active learning style grounded in an ethical framework that enables real-time self-appraisal as a basis for learning and development, even in complex situations

CS4.2.2.1a *Personal factors* – may include cultural bias, personal values and beliefs, motivations, style of communication, and gender differences in provision of care (eg female GPs typically provide longer consultations and more reasons for encounter per consultation than males[8,9] Refer to CS4.1.3 regarding therapeutic boundaries.

CS4.2.2.1b *Strategies to recognise and manage personal factors* – may include use of regular self-reflection and maintenance of self-awareness to recognise if personal factors are impacting on the quality of care being delivered. If this is identified, the GP needs to consider if they are able to continue providing care to the patient or whether a referral to another provider is warranted.

CS4.2.2.3c *Address potential conflict that may occur if a variety of professional roles are held* – this issue is pertinent to a number of consultation types and special interest areas of general practice. Examples include:

- patients who are family members, professional colleagues or close friends of the GP
- patients who have another type of professional relationship with their GP (eg accountant, lawyer, etc)
- rural GPs who carry out multiple roles within their community (eg involvement in local sporting clubs, council, etc).

One of the key factors to consider in addressing these potential conflicts is recognition of the importance of maintaining therapeutic boundaries in order to avoid power imbalances (in regards to the GP or to the patient being the holder of most significant power), which may then impact how the other party behaves (eg GPs feeling pressured into prescribing medications outside of guidelines or writing inappropriate sickness or disability certificates). Refer to CS4.1.3.

CS4.2.3 *Personal health and wellbeing* – refers to physical, psychological, social, spiritual and cultural wellbeing. The applications of this principle are important to acknowledge for each individual GP. General practice is a very rewarding and fulfilling, but sometimes can be very stressful and personally challenging profession. The health of GPs can be adversely impacted in many ways as a consequence of the type of work they do and it is important that they have insight into their own health needs and are able to prioritise them when required. It is important to recognise potentially risky situations or therapeutic relationships early and to minimise risk by engaging support from colleagues, other health professionals or organisations, and implement protective strategies.

Optimising physical safety at work is important to minimise risk of patient-initiated violence. It is vital to ensure that duress alarms are in place, develop and maintaining skills in de-escalation techniques, and confirm that all staff members are aware of the action plan if a situation that puts the staff or other patients at risk arises (refer to CS1.1.2.1c and CS1.1.2.2a).

Listening to their own advice as a GP is important; however, every healthcare professional should have their own GP to assist in implementing preventive strategies to ensure that they develop and maintain physical and psychological wellness, and are thus are able to deliver quality care. Fatigue management is an important aspect of self-care, particularly for doctors who work in rural and remote areas with onerous on-call responsibilities.

Identifying any blurring of boundaries in therapeutic relationships is another important area of risk (refer to CS4.1.3 and CS4.1.3.1b).

In the event of a physical or psychological impairment which may impact the GP's wellbeing or ability to manage their professional responsibilities, a robust management plan may need to be developed, working collaboratively with other health professionals as appropriate.

CS4.2.3.2b *Support for emotional reactions to confronting clinical situations* – identifying the need to access support may be the biggest obstacle for GP. As health professionals, GPs can be confronted with very traumatic and emotional situations. They often expect themselves to put their own emotional responses aside in order for them to appropriately deal with the situation at hand. It is important for GPs to recognise symptoms of stress and anxiety in response to traumatic or confronting situations and to access support, whether through formal or informal debriefing with colleagues.

CS4.2.3.3b *Occupational health risks* – may include impacts of stress and fatigue from working with vulnerable communities (eg Aboriginal and Torres Strait Islander peoples, homeless people, etc), working in remote and regional areas, and being placed in in emotionally challenging clinical situations (eg palliative care), etc. Risk minimisation strategies may include installation of duress alarms, awareness of safety issues in the workplace, ensuring safety during visits outside the practice, and routine debriefing after critical or potentially critical incidents, etc.

CS4.2.3.3c *Skills in debriefing colleagues* – there are a number of ways to approach debriefing colleagues after a critical or near critical incident. It is important to recognise that many professionals experience critical incident stress following an event. There is a broad spectrum of responses to such situations, which vary due to factors such as previous experiences, personality, feelings of responsibility, values, and beliefs of individuals involved.

It is recognised that clinical critical incidents may be under-reported due to health professionals' medico-legal concerns (particularly in regards to individuals being concerned about being blamed and/or disciplined as a result) and that debriefing is an important part of stress management to assist individuals to cope and reduce the risk of long-term effects. Some people find a peer-driven, therapist-mediated group approach is a useful debriefing structure. This may consist of an immediate response whereby the affected professional is provided support. This is followed by a second phase that consists of identifying what can be learned from the incident, rather than placing blame on any one individual, which many believe to be more useful if done as a group. The 'Mitchell model' to debriefing is one approach which may be useful.[10]

CS4.3.1.3b *Inclusive team-based approach to teaching and leadership* – may include identifying strengths and areas for improvement of the individuals within the team. It is helpful to focus on delegating responsibilities to match these skills, including teaching junior colleagues and providing clinical or other types of leadership (refer to CS3.2.3.1a).

CS4.3.1.4b *Best practice guidelines in general practice research* – doctors contribute to expanding the knowledge base of general practice through designing, coordinating and/or contributing to research in order to enable them to make informed, evidence-based decisions about patient care. Much of this evidence can only be obtained from research undertaken in the general practice setting. Contributions may be as simple as facilitating patient recruitment or access to patient data, but there are opportunities to play a more active role in research design and implementation. Participating in design or research depends on the research being performed to appropriate ethics and best practice standards.

Best practice guidelines in general practice research has ethical and clinical practice guidelines to which researchers need to adhere when running or participating in research (eg the NHMRC's *National statement on ethical conduct in human research* and *Good clinical practice in Australia*). Following such ethical and clinical practice guidelines is the responsibility of the researchers. GPs need to be aware that such guidelines exist and ensure that any research in which they participate has been approved by a human research ethics committee.

CS4.3.1.1c *Appropriate role boundaries* – the variety of professional roles may include teacher, clinician, supervisor, clinical leader, mentor, etc. Maintaining appropriate boundaries with junior colleagues is as important as therapeutic relationship boundaries with patients.

CS4.3.1.2c *Teach effectively and accountably* – effective teaching and mentoring includes:

- the use of effective communication skills (eg the importance of recognising the learning needs of peers and junior colleagues)
- development of rapport with learner/mentee
- reflection and provision of respectful feedback (positive before negative), which challenges individuals to self-reflect and develop knowledge and skills
- clear explanations as to reasoning behind use of clinical strategies
- formulating appropriate questions to encourage learners to develop problem-solving skills.

Extended teaching skills for learners who are more advanced in their training may include assisting learners to use reflective practice to encourage them to 'learn', rather than the GP 'teaching', facilitating development of skills by teaching in a way that caters to their individual learning style, and facilitating learning at an appropriate level of autonomy for the individual.

Demonstrating accountability for teaching identifies the important role which a teacher/mentor of junior colleagues plays when assisting in the development of clinical skills and knowledge. Exposure to patients is an important part of this process; however, the senior staff member needs to remain accountable for the outcomes when this occurs. The senior staff member should thus be mindful of the level of supervision required after assessment of the potential risks, taking into account the junior colleague's experience and knowledge.

Ensuring that an evaluation process is in place includes requests for provision of formal/informal and structured/unstructured feedback on quality of leadership, quality and content of education and mentoring, and development of effective ways to manage this information, and any subsequent communication and changes to the way in which team-based learning is carried out in the future.

CS4.3.1.3c *Safety net strategies* – may include developing triggered supervision for specific clinical issues or procedures (eg before prescribing Schedule 8 medications, suturing, corneal foreign-body removal, etc). This will depend on the skills and clinical experience of the individual, use of regular observation of consultations, and review of clinical notes in order to identify issues before they pose a potential risk.

CS4.3.1.5c *Procedures to ensure that research complies with relevant guidelines* – the NHMRC's *Australian code for the responsible conduct of research* and *National statement on ethical conduct in human research* are useful references. If designing or coordinating a research project, it is imperative to develop a robust research protocol that outlines key information for research assistants in regards to running the project. This ensures that participants are not put at risk and are adequately informed, etc.. It is also important to consult the relevant ethics committee for potentially high-risk projects (eg those which involve participation from vulnerable groups) and gain its approval before research is undertaken.

CS4.3.2 *Colleagues who may be in difficulty* – includes individuals who may be experiencing problems related to mental health (eg depression, anxiety, PTSD), bullying, personality (eg narcissistic personality disorder), substance use, and physical health. Identification and support of colleagues in difficulty is important; however, it is also imperative that GPs are aware of their mandatory reporting responsibilities if a colleague is conducting themselves in a way that meets the notification guidelines (eg practising while intoxicated, engaging in sexual misconduct, placing patients at risk due to an impairment, practising in a way which is a significant departure from professional standards, etc).[11]

CS4.3.2.1a *Professional resources that are available to assist health professionals who are in difficulty* – there are a number of resources available to assist GPs who may be experiencing difficulties. Encouraging individuals to have their own regular GP is very important. The Australasian Doctors Health Network is a helpful resource that contains a useful list of resources and contacts in the event immediate assistance is needed. Other important support structures include offering professional debriefing after a critical incident (refer to CS4.2.33c), professional counselling (refer to CS4.2.3.2b), and encouraging colleagues to contact their medical defence organisation in the event of a clinical incident which has potential legal consequences.

Individuals may sometimes demonstrate a lack of insight into the impact their physical or psychological health issues, or personality traits has on their ability to practice safely. If this occurs, and the GP is resistant to accessing help, the GP colleague has a duty of care to consider making a notification to AHPRA. This can be done anonymously.

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Domain 5. Organisational and legal dimensions

'Make a habit of two things: to help; or at least to do no harm' – Hippocrates

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
CS5.1 GPs use quality and effective practice management processes and systems to optimise safety	**CS5.1.1** *Infection control and relevant clinical practice standards* are maintained	**CS5.1.1.1a** Describe and demonstrate strategies for *infection prevention and control*	**CS5.1.1.1b** Identify the role of RACGP practice standards and integrate them into clinical care	**CS5.1.1.1c** Appraise and maintain compliance with RACGP practice standards
			CS5.1.1.2b Implement best practice guidelines for infection control measures	
			CS5.1.1.3b Identify the role and relevance of *clinical indicators* in improving quality of care	
	CS5.1.2 Effective *clinical leadership* is demonstrated	**CS5.1.2.1a** Identify examples of clinical leadership	**CS5.1.2.1b** Identify opportunities to lead an improvement in quality care	**CS5.1.2.1c** Drive improvements in quality of care within practice setting
		CS5.1.2.2a Evaluate the key characteristics of, *and obstacles to*, *effective clinical leadership*	**CS5.1.2.2b** Support peers to step into leadership roles	**CS5.1.2.2c** Identify and manage obstacles to demonstrating leadership in the practice setting
	CS5.1.3 *Relevant data* is clearly documented, securely stored and appropriately *shared* for quality improvement	**CS5.1.3.1a** Identify *key patient information that needs to be collected* and stored	**CS5.1.3.1b** Formulate strategies to maintain *medical record data quality*	**CS5.1.3.1c** Review and revise data collection and storage to meet legislative requirements
		CS5.1.3.2a Maintain *comprehensive and accurate* clinical notes	**CS5.1.3.2b** Utilise strategies to maintain accurate medication records	**CS5.1.3.2c** Maintain ethical standards when using patient data for research or quality improvement activities
		CS5.1.3.3a Describe *key aspects of secure storage* of data		
		CS5.1.3.4a Describe the *legislative requirements relevant to the use of patient information* for research or quality improvement purposes		

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	**General practice under supervision**	**General practice – lifelong learning**
	CS5.1.4 Quality and safety is enhanced through the effective *use of information systems*	**CS5.1.4.1a** Identify the *key principles of appropriate use of health information systems*	**CS5.1.4.1b** Utilise *best practice guidelines* for appropriate use of health *information systems*	**CS5.1.4.1c** Review and address clinical issues that arise as a result of inadequacies in health information systems
		CS5.1.4.2a Describe the benefits and risks associated with health information systems	**CS5.1.4.2b** Demonstrate *efficient use of recall systems* to optimise health outcomes	**CS5.1.4.2c** Appraise and effectively utilise *eHealth systems* to optimise care
				CS5.1.4.3c Appraise effectiveness of recall systems to maximise quality of care
	CS5.1.5 Effective *triaging and time management structures* are in place to allow timely provision of care	**CS5.1.5.1a** Outline the principles of *medical triage*	**CS5.1.5.1b** Formulate *strategies to maintain effective time management*	**CS5.1.5.1c** Support and mentor colleagues in effective triaging and development of time management skills
			CS5.1.5.2b Address barriers to, and implement criteria for, effective triage	
			CS5.1.5.3b Prioritise patient consultation times according to severity of presenting illness in order to optimise care	
	CS5.1.6 Ethical *business processes and practices, and effective governance structures* are implemented	**CS5.1.6.1a** Identify any perceived unethical business practices in place of work		**CS5.1.6.1.c** Recognise and address any potential or actual breaches of ethical business practices
		CS5.1.6.2a *Access support to address concerns* regarding unethical processes, structures or practices	**CS5.1.6.2a** Identify ethical business principles in place of work and address any practices that do not comply	
CS5.2 GPs work within statutory and regulatory requirements and guidelines	**CS5.2.1** *Patient confidentiality* is managed appropriately	**CS5.2.1.1a** Define the key responsibilities for medical professionals in regards to confidentiality	**CS5.2.1.1b** Identify and manage *situations where duty of care responsibilities are not compliant with confidentiality requirements*	**CS5.2.1.1c** Review any *breaches of confidentiality* and review processes to reduce future risk
		CS5.2.1.2a Explain confidentiality requirements to patients as appropriate	**CS5.2.1.2b** Identify and demonstrate sensitive management of mandatory and voluntary reporting responsibilities	

Core skills	Competency outcomes	Criteria for stage of training		
		Pre-general practice	General practice under supervision	General practice – lifelong learning
	CS5.2.2 *Shared decision making and informed consent* are explained and obtained	**CS5.2.2.1a** Outline the principles of *patient autonomy*, shared decision making and informed consent	**CS5.2.2.1b** Demonstrate appropriate utilisation of shared decision making and informed consent	**CS5.2.2.1c** Review and revise existing policies and procedures that relate to informed consent and shared decision making
		CS5.2.2.2a Identify barriers to *provision of informed consent and shared decision making*	**CS5.2.2.2b** Determine *patient competency to provide informed consent*	
			CS5.2.2.3c Integrate legislative requirements into care of individuals who are unable to provide consent	
	CS5.2.3 *Medico-legal requirements are integrated into accurate documentation*	**CS5.2.3.1a** Identify the legal documents and reports that form as part of the professional life of a doctor	**CS5.2.3.1b** Accurately complete legal documentation appropriate to the situation	**CS5.2.3.1c** Review and revise documentation to reflect current legal and legislative requirements
		CS5.2.3.2a Describe criteria for reportable deaths and accurately complete death certificates	**CS5.2.3.2b** Seek support from other professionals to complete complex or unclear documentation	

Context and application: Domain 5

CS5.1.1 ***Infection control and relevant clinical practice standards*** – refers to the standards developed as a template to assist in improving quality and safety of general practice service provision in Australia (eg the RACGP's *Standards for general practices*[1] and *Infection prevention and control standards*,[2] and the NHMRC's *Australian Guidelines for the prevention and control of infection in healthcare*[3]). The aim of clinical standards is to manage risk and to deliver better health outcomes for patients.

CS5.1.1.1a ***Infection prevention and control*** – includes:

- hand hygiene
- environmental hygiene
- body fluid spills management
- sterilisation
- immunisation of self and staff
- standard and transmission-based precautions (eg outbreak control, including identifying individuals who may have communicable diseases and implementing appropriate procedures to minimise risk of spread)
- healthcare-associated infection surveillance, including notifiable diseases.

CS5.1.1.3b ***Clinical indicators*** – these are markers of quality care and can help to assist in development of quality improvement strategies. Clinical indicators may include:

- patient experience surveys
- proportion of clinical files with health summaries and up-to-date adverse drug reaction warnings
- provision of care that adheres with clinical guidelines
- use of interpreter service for patients of linguistically diverse backgrounds
- quality of referral letters
- currency of medication lists
- evidence of timely review of test results
- maintenance of infection control standards
- proportion of files with appropriate recalls.

CS5.1.2 ***Clinical leadership*** – may be demonstrated by improving clinical outcomes through quality and safety developments in healthcare provision, at both micro and macro levels. Strong clinical leadership is essential for robust clinical governance. Clinical leadership responsibilities include:

- determining priorities for allocation or resources to support quality patient care
- contributing to the development of a workplace culture of trust and honesty in order to encourage open discussion about adverse events without blaming individuals
- developing systems to flag and respond to concerns about patient care
- monitoring clinical performance indicators.

CS5.1.3 ***Relevant data*** – a term which may be used to describe any information related to patient demographics, or which is collected in regards to health, such as diagnoses, measurable parameters, referrals, management, therapeutics.

CS5.1.3 ***Shared appropriately*** refers primarily to the need for the patient's informed consent prior to information being shared with external parties. The exceptions to this are situations where mandatory reporting legislation takes precedence (refer to CS5.2.1.2b).

CS5.1.3.1a *Key patient information that needs to be collected and stored* – information from a legible health record containing all relevant health information, which includes*:*

- patient demographics (name, date of birth, gender, contact details, next of kin details, Medicare number)
- cultural status, including migration history (to assist with risk assessment and advice)
- preferred language (whether an interpreter is required)
- medical information (allergies, up-to-date list of health problems)
- medication (up-to-date list)
- family history (particularly inheritable conditions relevant to the individual)
- social and occupational history (relationship status, sexuality, gender identification, education level, type of occupation)
- lifestyle risk factors (smoking, alcohol intake, illicit drug use, etc)
- health screening (whether up-to-date with developmental screening, blood pressure, mammograms, Pap smears, annual diabetes assessments, etc).

CS5.1.3.2a *Comprehensive and accurate* – refers to the importance of ensuring that all of the relevant information for an individual is incorporated into the clinical notes (as outlined CS 5.1.3.1a). Accuracy of clinical notes is always important, but it is especially vital in regards to consultations where mandatory reporting may be necessary, legal documentation is being completed (refer to CS5.2.3), or where there is a forensic component in which clinical notes may be used as evidence in court.

CS5.1.3.3a *Key aspects of secure storage* – may include the use of unique healthcare identifiers, ensuring that electronic health information is transferred securely, ensuring that clinical information is password-protected and regularly backed-up to a secure server, etc.

CS5.1.3.4a *Legislative requirements relevant to the use of patient information* – outlined in the Australian Government's *Privacy Act 1988*. Health information is rightly denoted to be 'sensitive information' and it is imperative that it is securely stored and confidentiality is maintained. The primary exceptions to these requirements arise when mandatory reporting legislation takes precedence.

The *Privacy Act 1988* includes additional requirements in rare situations where maintaining confidentiality may place someone else at significant risk (eg an individual who has had a genetic test that demonstrates a risk of a serious health condition who then refuses to provide consent to inform relatives who may also be affected).[4]

CS5.1.3.1b *Medical record data quality* – includes creating structures within consultations to ensure that important information, such as demographic information, current medical conditions and current medications and allergies, are up-to-date. Use of the PCEHR can help to reduce patient harm and adverse events, and enhance communication between health service providers. Regular clinical audits of medical records to evaluate the appropriateness of care, or how much it aligns with recommendations, can be a useful tool.

Useful resource

- Quality health records in Australian primary healthcare: A guide, www.racgp.org.au/yourpractice/business/tools/support/qualityhealthrecords

CS5.1.4 *Information systems* – may include:

- computerised or hand-written documentation
- the use of effective recall systems to optimise follow-up and continuity of care
- professional handover regarding high-risk individuals
- clear and concise documentation of diagnosis

- management and follow-up plans
- utilisation of PCEHR.

Effective health information systems are cost-effective, context-relevant, secure, user-friendly and reliable in assisting assist with care delivery and health outcomes. General practice information systems can refer to computers with adequate internet access, security systems, video-conferencing equipment, etc.

Useful resource

- National E-Health Transition Authority publication e-Health Clinician's Desktop User Guide – GP Version). Section 3.2.1.

CS5.1.4.1a *Key principles of appropriate use of health information systems* – to uphold patient privacy and confidentiality, and optimise quality continuity of care and communication by utilising health information systems (eg password-protected medical software, ensuring only clinical staff have access to clinical files, ensuring any patient information sent by email is only done through encrypted software, etc).

CS5.1.4.2b *Efficient use of recall systems* – describes the information systems used to identify and notify individuals in need of follow-up, including further investigation or specialist referral, after routine screening or abnormal. The GP's consequent concise and comprehensive handover provided verbally or through documentation enables continuity of care and reduces clinical risks. Information technology (IT) is important when considering recall options for individuals with visual or hearing impairment, who have problems with literacy, or who have no fixed address or move frequently.

CS5.1.4.2c *eHealth systems* – may include use of:

- clinical software
- verbal communication with specialised organisations and clinics
- telehealth facilities in remote and rural areas
- PCEHR
- encrypted email to transfer patient information
- a knowledge of useful health tools and applications available for professionals and patients (eg e-mental health interventions).

Useful resources

- RACGP Standards for general practices offering video consultations, www.racgp.org.au/download/Documents/Standards/2011standardsforvideoconsultations.pdf
- RACGP position statement: Personally Controlled Electronic Health Record (PCEHR) www.racgp.org.au/yourracgp/news/reports/20120412pcehr

CS5.1.5 *Triaging and time management structures* – triaging structures refers to the frameworks which assist in appropriately prioritising patients to be assessed, including:

- current symptoms and severity
- amount of time symptoms have been present
- whether the individual recently travelled to a high-risk area for particular communicable diseases
- existing vulnerabilities and thus a risk of acute deterioration (eg age and existence of concomitant illness).

Time management structures may include:

- flexible appointment scheduling that allows for urgent walk-in appointments
- scheduling regular breaks to allow for consultations that run over time

- routinely booking long appointments for individuals with complex health problems or communication issues
- allotting time for completion of care plans, home visits, etc.

CS5.1.5.1a *Medical triage* – refers to the process by which individuals are prioritised for care based on their clinical urgency. This refers to the severity of their symptoms and signs and thus their requirement for timely assessment and management.

CS5.1.5.1b *Strategies to maintain effective time management* – may include provision of 'on the day' appointments, long appointments for counselling, acceptance of walk-in patients in certain circumstances, and long appointments as a default for patients with known complex needs, etc.

CS5.1.6 *Business processes, practices and effective governance structures* – includes processes related to:

- management of patient and staff feedback
- practice quality improvement activities achieved through clinical audits
- structures related to security of health information
- robust processes related to staff induction and clinical risk management structures
- anti-discrimination and gender-balance practices.

GPs should also consider the importance of ensuring that any potential conflicts of interest regarding financial remuneration and patient care are recognised, declared and managed. This helps to make sure such conflicts of interest do not impact the provision of informed consent, professional contracts are fair and within codes of ethics, and business processes do not reduce quality of care and thus risk poor health outcomes, etc.

CS5.1.6.2a *Access support to address concerns* – may be from peers, senior colleagues or medical indemnity providers.

CS5.2.1 *Patient confidentiality* – refers to legal management which is in the context of the situation and the patient and can be described as one of the core duties of health professionals. This situation refers to the professional obligation to respect patient privacy by keeping any information which is identifiable to an individual private, emphasising that it is the professional's responsibility to ensure that this privacy is maintained. There are, however, exceptions to this obligation, including the need to release records if a legal subpoena is received; or in situations where duty of care is the predominant factor, wherein the professional believes the individual's capacity for consent is impaired and they pose a risk to themselves or to others if information pertaining to their current risk is not shared with individuals or organisations with the capacity to provide protection from that risk.

CS5.2.1.1b *Situations where duty-of-care responsibilities are not compliant with confidentiality requirements* – refers to clinical situations where the need for patient privacy is overridden by the need to protect the general public or the individual in question. Examples include:

- mandatory reporting of communicable diseases (full details of the individual are not required for some notifications)
- recommendation for involuntary admission under the relevant mental health jurisdictional laws
- mandatory reporting of suspected child abuse
- mandatory reporting of suspected impairment of professional colleagues
- individuals who have guardians who hold medical power of attorney
- individuals with occupational injuries being managed under WorkCover*.*

CS5.2.1.2b *Sensitive management of mandatory and voluntary reporting responsibilities* – these reporting responsibilities are developed under law to provide a framework for the health service delivery process, and to address health service provision and public health issues. They are developed to provide clear and consistent direction to achieve quality health outcomes and define professional accountability. Examples include:

- communicable diseases notification requirements
- drugs and poisons requirements (particularly Schedule 8 medications)
- the recommendation for involuntary admission under the relevant mental health jurisdictional laws (particularly involuntary admission)
- mandatory reporting of professional colleagues who demonstrate impairments in their capacity to practise, etc.

The issues which may lead to these reports are broad and varied. Most necessitate careful, diplomatic management through the use of clear communication by the GP to the affected person(s), where the rationale for the report, as well as for what the information in the report will be used and the likely next steps for the individual, is explained.

CS5.2.2 ***Shared decision making and informed consent*** – are based upon provision of accurate and comprehensive information, tailored to the individual's sociocultural context (particularly the level of health literacy), the options available, and the risks and benefits of these options to the individual. In determining capacity to provide consent, the individual needs to demonstrate to the GP a clear appreciation and understanding of the facts, implications and consequences of an action. The individual must also show they have adequate reasoning faculties and are in possession of all relevant facts at the time consent is given.

'Capacity to provide consent' is a legal term with a variety of definitions. Capacity is dependent on the decision being made and is specific to each decision in healthcare settings (incapacity to one area may not mean incapacity for all decisions). It is prudent for GPs to assume the existence of capacity and seek to overcome any communication barriers that may be present. Most people can be supported in making their own decisions, including whether to involve a spouse, family members, friends or carers in the process. In the uncommon situations where an individual's capacity is thought to be impaired, assistance can be obtained from the relevant office of the public advocate or public guardian. Requirements for consent do not only relate to management plans for individuals, but Include consent to have a third party in the room for educational purposes (eg a supervisor or external clinical teaching visit assessor).

Useful resource

- Bird S. Consent to medical treatment: the mature minor. Aust Fam Physician 2011:40(3):159–60, www.racgp.org.au/download/documents/AFP/2011/March/201103bird.pdf

CS5.2.2.1a ***Patient autonomy*** – refers to the individual's right to make decisions about their medical care, whereby the GP provides health education and information appropriate to the individual to enable an informed decision.

CS5.2.2.2a ***Provision of informed consent and shared decision making*** – includes factors which impact capacity to provide informed consent (refer to CS5.2.2.2b).

CS5.2.2.2b ***Patient competency to provide informed consent*** – when considering competency to provide consent, individuals from these following groups, or who are involved in the following clinical scenarios, may warrant more detailed assessment and consideration:

- older patients
- young people (younger than 19 years of age)
- individuals with cognitive impairment
- individuals who have involuntary treatment orders
- use of restraint
- involuntary admissions.

It should be recognised that capacity is a concept that may vary between consultations for individuals who have an unstable mental or physical health condition and thus may need to regularly be assessed if significant decisions need to be made.

Useful resource

- Office of the Public Advocate. Medical consent, www.publicadvocate.vic.gov.au/medical-consent (Includes useful flow chart for health professional decision making around capacity for consent.)

CS5.2.2.3c *Legislative requirements into care of individuals who are unable to provide consent* – includes temporary and ongoing medical power of attorney, understanding of guardianship arrangements and advanced care directives.

Useful resources

- www.australia.gov.au/content/powers-of-attorney
- www.racgp.org.au/your-practice/business/tools/support/acp

CS5.2.3 *Medico-legal requirements are integrated into accurate documentation* – includes:

- knowledge of criteria for certifiable and reportable deaths
- effective and accurate completion of work capacity or fitness certificates (eg Centrelink, WorkCover, sick certificates), focusing on capacities the patient has rather than those they don't, and acknowledging that they strongest predictive factors for a return-to-work concern an individual's expectations, number of sick leave days taken in the past, and presence of somatic disorders
- understanding of criteria and resources to assist, to deem an individual fit to drive
- medical reports for criminal proceedings (eg documentation of injuries resulting from alleged family violence, child abuse or other types of violence)
- recommendation for involuntary admission under the relevant mental health jurisdictional laws
- completion of advanced care directives and assessment of capacity to provide informed consent/testamentary capacity
- mandatory reporting of suspected child abuse, understanding of occupational health and safety (OH&S) legislative requirements.

Most states and territories now use the same OH&S legislation (eg needle-stick injuries, handling of bodily fluids, infection guidelines), carer allowance applications, will preparation, etc.

References

1. The Royal Australian College of General Practitioners. Standards for general practices. 4th edn. Melbourne: RACGP, 2010. Available at www.racgp.org.au/your-practice/standards/standards4thedition [Accessed 9 December 2015].
2. The Royal Australian College of General Practitioners. Infection prevention and control standards. 5th edn. Melbourne RACGP, 2014 Available at www.racgp.org.au/download/Documents/Standards/infectionpreventionandcontrolstandards.pdf [Accessed 9 December 2015].
3. National Health and Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare 2010. Available at www.nhmrc.gov.au/guidelines-publications/cd33 [Accessed 9 December 2015].
4. Australian Government. Office of the Australian Information Commissioner. Business resource: Key health privacy concepts. Available at www.oaic.gov.au/engage-with-us/consultations/health-privacy-guidance/business-resource-key-health-privacy-concepts [Accessed 9 December 2015].

Useful resource

- www.rch.org.au/clinicalguide/guideline_index/Child_Abuse_Guideline

Requirements for competence

Required knowledge	Required attitudes
• Holistic approaches and perspectives • Knowledge of own scope of safe practice • Australian healthcare system • Preventive health, health promotion theory and practice • Community and patient resources • Duty of care theory and practice • Critical evaluation of demographic data and health information • Access and equity in the context of the patient and the setting • Human body and disease • Ethical principles in medicine • Legislation relevant to general practice • Safe management of common and important presentations in general practice • Professional resources and guidelines	• Empathy • Ability to deal with uncertainty and ambiguity • Collegiality • Self-awareness • Curiosity • Professionalism • Commitment to learning and development • Commitment to contribute to improving the evidence base for general practice research • Respect for patient autonomy • Commitment to self/family care
Required skills	**Methods of assessment**
• High-level problem solving • Critical thinking • Cultural safety • High-level communication skills (verbal and non-verbal including de-escalation skills) • Negotiation • Identifying relevant evidence • Integrating evidence into decisions and actions • Assessment of opportunities to participate in general practice research • Comprehensive history taking social, cultural and medical • Competent physical examinations • Patient advocacy • Developing management plans with patients, their family/carers and other providers • Essential and relevant procedural skills • Comprehensive diagnostic skills • Patient-centred and safe clinical decision making • Safe and appropriate prescribing • Networking • Multidisciplinary teamwork • Setting and up working with practice systems • Reflective practice	• Small-group projects • Literature review • Essays • Observations • Simulations • Role-play • Third-party reports • Written and verbal questioning • Reflective practice reports • Participation in face-to-face and online assessment activities

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