National Undergraduate Family Medicine Learning Goals and Objectives

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# Table of Contents

**BACKGROUND AND INTRODUCTION** ................................................................................................................................. 1

**PART 1 — THE FOUR PRINCIPLES OF FAMILY MEDICINE** ................................................................................................. 5

A. THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN ........................................................................................................ 5
B. THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN ............................. 8
C. THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION ......................................................... 9
D. FAMILY MEDICINE IS COMMUNITY BASED .................................................................................................................... 10

**PART 2 — CANMEDS ORGANISATION OF THE NATIONAL GOALS AND OBJECTIVES** ................................................................. 13

➢ CanMEDS 1—Medical Expert ........................................................................................................................................ 13
➢ CanMEDS 2—Communicator ....................................................................................................................................... 14
➢ CanMEDS 3—Collaborator ............................................................................................................................................ 15
➢ CanMEDS 4—Manager Health Manager .................................................................................................................. 15
➢ CanMEDS 5—Advocate ................................................................................................................................................. 16
➢ CanMEDS 6—Scholar .............................................................................................................................................. 17
➢ CanMEDS 7—Professional ........................................................................................................................................... 17

**APPENDIX 1.** Symptoms and; Specific Diagnoses or Reasons for Office Visits .............................................................. 19

**APPENDIX 2.** Office Procedural Skills ............................................................................................................................. 23

**APPENDIX 3.** Broad Drug Classes ........................................................................................................................................ 25
Background and Introduction

Family medicine is a community-based discipline that provides educational opportunities often not available in other disciplines. Patients present earlier with their illnesses than they do in other settings, and often with complex mixtures of physical, emotional, and social problems. Family physicians (FPs) fill a myriad of roles in the health care system, and this working document focuses on the community-based generalist family practice model. The manuscript sets out national goals and objectives for undergraduate medical education from a family medicine perspective, with a focus on preparing graduates with a generalist orientation. These national undergraduate learning goals and objectives were developed through a review of the literature, an examination of existing goals and objectives from the various institutions across Canada, and input from key stakeholders. The development of the initial document was followed by broad consultation and multiple revisions incorporating both stakeholder input and other recommendations.

Users of this document should keep the following points in mind:

- While the focus of these goals and objectives is family medicine, undergraduates acquiring these goals and objectives at an appropriate level would be seen as generalist physicians well prepared for a residency in any discipline.
- These goals and objectives are not confined to clerkship, but span the entire undergraduate curriculum.
- While the goals and objectives are comprehensive, not all of them are likely to be covered exclusively by a family medicine curriculum. However, most should be addressed by the overall curriculum so that a generalist physician is produced by the end of medical school.
- This document provides a menu, from which undergraduate family medicine programmes can select goals and objectives that fit their needs and can be modified to suit their contexts.
- This manuscript is not an accreditation document against which departments will be measured. It should be considered a set of guidelines that departments can use to reach their own goals.
- This manuscript is a national document, which faculties of medicine, health sciences, or medicine and dentistry can use to assess the degree to which they are meeting specific family medicine-related goals and objectives.
- Because of the heterogeneity of programmes across Canada, no effort has been made to define a particular sequence or year in which the goals should be met. The expectation is that in the early years of undergraduate curricula, each goal and objective would be covered in less depth than in later years.
- These goals and objectives could be met through various experiences in an undergraduate curriculum, which would include but not be limited to the following:
  - The classroom during the pre-clinical years.
  - The clinical or clinical skills setting during the pre-clinical years.
  - Longitudinal urban experiences.
  - Longitudinal rural experiences.
  - Block urban experiences.
  - Block rural experiences.
• Electives.
• Research.
• Mentorship.
• Shadowing.

The committee felt that students must have a mandatory six- and preferably eight-week family medicine clerkship rotation, as well as the opportunity for senior family medicine electives. A significant number of these should be offered in rural settings. An early longitudinal experience in an FP’s office would also be ideal.

• While these goals and objectives are not exit competencies, they are a comprehensive assembly of the family medicine knowledge required at the undergraduate level.

These goals and objectives have been organised using two frameworks: the four principles of family medicine (part 1) and the CanMEDS 2000 themes (part 2). Those wishing to use the CanMEDS 2000 organisation of objectives are directed to the appropriate four principles section because the objectives listing in the CanMEDS section is abbreviated to major headings.

Please note that goals are highlighted in **bold** type, and objectives are indicated by bullet points.
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Approval

Approved by the Board of Directors of The College of Family Physicians of Canada on December 7, 2005

Comments

Please make suggestions or comments at ug_learningobjectives@cfpc.ca for review by undergraduate family medicine directors.
PART 1
The Four Principles of Family Medicine

A. THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN.

1. The learner will be able to describe how common illnesses present differently in the family practice environment than in the specialist setting: (CanMEDS 1)
   - Prevalence of diagnoses/illnesses in the community.
   - Ill-defined nature of early presentations.
   - Greater uncertainty because patients present at an early, undifferentiated stage of their illnesses — in up to 50% of visits, definitive diagnosis is not possible.
   - Time as a diagnostic tool.
   - Appropriate follow-up management.
   - Appropriate use of diagnostic tools. Because disease prevalence is usually lower in a family practice setting than in a specialty service, the predictive value of many investigations is poor; tests that are useful in a specialty discipline are of little or no value in a family practice.
   - Appropriate use of consultation with other health care providers.
   - Recognition of variants of normal that are not classified as illness.

2. The learner will be able to carry out a patient-centred interview that will include the following: (CanMEDS 2)
   - Recognition of the difference between illness and disease and application of this distinction in assessment and management of patient problems.
   - Routine exploration of patients’ experiences of illness — their feelings, their ideas, effects of the illness on function, and expectations for care. (The acronym FIFE is often used as an aide-mémoire for these issues.)
   - Exploration of patients’ personal history and context (family, job, school, geography, environment, etc.).
   - Shared decision-making/finding common ground — supporting patients to have as active a role in all decisions affecting their health care as they desire.
   - Patient education.
   - Recognition of a range of approaches to collaborating with patients, and of when each approach (deliberative, interpretive, informative, and paternalistic) is most appropriate.

3. The learner will demonstrate effective communication skills in data gathering. The learner will be able to do the following: (CanMEDS 2)
   - Use appropriate open-ended questions.
   - Use appropriate closed-ended questions.
   - Demonstrate active listening.
• Paraphrase.
• Use non-verbal indicators of engagement with the patient.
• Use appropriate time management.

4. The learner will demonstrate sensitivity when asking intimate questions of patients. The following are examples of intimate issues: (CanMEDS 2)
   • Drug use.
   • Alcohol use.
   • Sexual practices.
   • Abuse history.

5. The learner will be able to take a history that includes the non-biological determinants of health. These include the following: (CanMEDS 5)
   • Housing.
   • Socioeconomic status.
   • Social network.
   • Education.
   • Work.
   • Culture.
   • Environment.

6. The learner will use appropriate record keeping when caring for patients. For example, the learner will construct the following: (CanMEDS 1)
   • Structured notes (e.g., subjective, objective, assessment, plan [SOAP] structure).
   • Well-organised and comprehensive problem lists.
   • Well-organised summaries/consultations to another health care provider.

7. The learner will understand the issues around consent to treatment and substitute decision making: (CanMEDS 1 and 2)
   • Informing patients about options for management and consequences of each choice.
   • Advance directives.
   • Power of attorney.
   • Competency assessment.
   • Working with substitute decision makers.
8. The learner will use the patient-centred clinical method to conduct a supervised office visit* for common presentations, which may include both symptoms and diagnoses. (See Appendix 1.) (CanMEDS 1)

* The supervised office visit should include culturally sensitive, age-appropriate history-taking and focused physical examination; use of appropriate investigations; formulation of a diagnosis; and development of a management plan that involves allied health professionals, community supports, drug therapy (see Appendix 3), patient education, and follow-up management at an appropriate level for the student’s training.

9. The learner will demonstrate the basic correct technique in common office procedural skills. (See Appendix 2.) (CanMEDS 1)

10. The learner will show a basic and appropriate level of understanding of a pharmacotherapeutic approach to treating primary care conditions, considering, at an appropriate level, pharmacodynamics, pharmacokinetics, side effects, important drug interactions, dosages, and costs. (See Appendix 3.) (CanMEDS 1)

11. The learner will demonstrate comfort in the use of non-pharmacologic modalities: (CanMEDS 1)

   - The physician-patient relationship.
   - Supportive therapy.
   - Specific approaches (e.g., cognitive-behavioural therapy, family approaches, other modalities).
   - Motivational interviewing (based on “stages of change” theory).
   - Lifestyle counselling (e.g., on nutrition, exercise).

12. The learner will demonstrate a general approach to palliative care issues: (CanMEDS 1)

   - Pain assessment.
   - Pain control.
   - Pain equivalency.
   - End-of-life issues.
   - Control of other symptoms (e.g., shortness of breath, anxiety, nausea and vomiting, anorexia, cough, diarrhoea, constipation, hiccups).
   - Providing comfort and support (to patients and families).
   - Supporting caregivers.
   - Assessing and providing support for spiritual issues.
B. THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE FAMILY PHYSICIAN’S ROLE.

1. The learner will recognise that the patient-physician relationship is central to the practice of family medicine: (CanMEDS 2)
   - Communication with patients, family, communities, and colleagues (see skilled clinician).
   - Respect for differences in beliefs and backgrounds.
   - Establishment of professional relationships with patients, families, communities, and colleagues.

2. The learner will appreciate the value of continuity of care for developing a deep knowledge of patients: (CanMEDS 1)
   - Ongoing patient care visits over time for chronic and episodic care.
   - Home visits.
   - Nursing home visits.
   - Chronic care.

3. The learner will demonstrate application of an ethical framework in the clinical decision-making process: (CanMEDS 1 and 5)
   - “Four principles” approach:
     - beneficence.
     - non-maleficence.
     - autonomy.
     - justice.
   - Special features of ethical decision making in family medicine.

4. The learner will demonstrate an understanding of the key components of a professional relationship: (CanMEDS 5 and 7)
   - Respect for patients and patient diversity (i.e., thought, belief, culture), including patients who make decisions at variance with the learner’s.
   - Respect for other health care providers, teachers, and learners.
   - Boundary issues that arise with patients.
   - Confidentiality.
   - Advocacy.
   - Consent.
   - Punctuality.
   - Fidelity/reliability.
   - Life-long learning.
   - Threats to professionalism (conflicts of interest, personal/ system limitations, etc.).
5. The learner will reflect on his or her development as a physician: (CanMEDS 7)
   - Respect for self/self care, with recognition of the importance of personal health on one’s ability to care for others.
   - Appreciation of personal development/self reflection.

C. THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.

1. The learner will be able to describe a population and identify how he or she could work with that population to improve its health: (CanMEDS 3 and 5)
   - Ability to describe population determinants of health.
   - Ability to describe an approach to disease prevention and health promotion.
   - Participation in population-based disease-prevention/health-promotion activities.
   - Recognition that individual-based approaches may be at variance with population-based approaches to disease prevention/health promotion (resources, ethical frameworks, etc.).

2. The learner will be able to identify what health-promotion and disease-prevention activities are appropriate to particular populations, using the Canadian Task Force A and B recommendations. (The learner should know the A and B recommendations with a high burden of illness and the important/controversial C and I recommendations. See the Canadian Task Force Web site for the listing http://www.ctfphc.org/) (CanMEDS 1 and 5)

3. The learner will be able to demonstrate how to introduce health-promotion and disease-prevention activities into the clinical encounter: (CanMEDS 2)
   - Awareness of stages of change theory.
   - Awareness of systems for health-promotion and prevention activities in the office.

4. The learner will be able to describe some of the methodological and ethical issues related to screening healthy and at-risk populations: (CanMEDS 4)
   - Ethical issues including, for example, cost, benefit versus harm, opportunity cost, burden on the health care system).
   - Methodological issues (e.g., sensitivity, specificity, biases).
   - Potential conflicts between practice guidelines and patient autonomy and preference.

5. The student will demonstrate self-directed life-long learning: (CanMEDS 6)
   - Identification of personal learning needs.
   - Identification of appropriate learning resources.
   - Demonstration of efficient and appropriate information searching, using a wide range of resources.
   - Taking a reflective and mindful approach to learning.
   - Assisting/facilitating the teaching and learning of others in all aspects of medical care.
• Appreciation of the role research has in posing and solving questions in family medicine.
• Acknowledgement of the role of patients as teachers.

6. The learner will be able to demonstrate evidence-based decision making to aid patients and him- or herself with clinical decisions: (CanMEDS 6)
   • Identification of evidence-based resources.
   • Demonstrated ability to appraise a variety of resources critically.
   • Synthesis of relevant resources/information to help make a clinical decision.
   • Integration of evidence with clinical expertise and patient values.

7. The learner will understand the patient, personal, and professional impact of medical error: (CanMEDS 7)
   • Recognition of personal limits.
   • Recognition of system limits.
   • Acting appropriately to serve patient interests.
   • Appropriate disclosure of error to patients.

D. FAMILY MEDICINE IS COMMUNITY BASED.

1. The learner will understand the team approach in the care of ambulatory patients:
   (Note: The team is a group of individuals who work toward the resolution of a patient problem.) (CanMEDS 3 and 5)
   • Benefits of an interdisciplinary approach.
   • Challenges of an interdisciplinary approach.
   • Contributions of all health care team members.
   • Working with other health care providers within the team.
   • Seeking and applying appropriate resources within the hospital, the patient’s family, and the community to aid treatment and rehabilitation.

2. The learner will demonstrate an understanding of the structure and function of the health care system and the role of the family physician and family medicine in this system:
   (CanMEDS 3 and 4)
   • Role of municipal health care organisations.
   • Role of provincial health care organisations.
   • Role of federal health care organisations.
   • Role of non-governmental health care organisations.
   • Role of public health organisations.
   • Governance of the health care system.
   • Financing of the health care system.
   • Primary health care reform.
3. The learner will understand the special needs of children and other vulnerable groups with respect to community resources: (CanMEDS 5)
   - Child protection legislation.
   - Community supports.
   - Community living.

4. The learner will demonstrate the ability to liaise with appropriate community resources in the care of a patient: (CanMEDS 3 and 5)
   - Securing appropriate community resources available to aid a patient.
   - Transferral of care (hospital, community, long-term-care with a community organisation).
   - Sharing of care (hospital, community, long-term-care with a community organisation).

5. The learner will be able to formulate a written or verbal referral plan and to justify this plan with respect to the following characteristics: (CanMEDS 3)
   - Clarity.
   - Appropriateness.
   - Succinctness.

6. The learner will demonstrate an understanding of a range of activities and organisations that will promote the well-being of his or her patients (e.g., community agencies, self-help groups, advocacy): (CanMEDS 5)
   - Valuing their importance.
   - Volunteering or participating in activities that promote well-being.
   - Support of patients or others participating in these activities.

7. The learner will demonstrate knowledge of reportable illnesses, as they are defined in public health terms: (CanMEDS 3)
   - The list of illnesses used should be the one determined by each province’s reporting requirements.
PART 2
CanMEDS Organisation of The National Goals and Objectives

CanMEDS 1—Medical Expert

THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN.
➢ The learner will be able to describe how common illnesses present differently in the family practice environment in comparison with the specialist setting.
➢ The learner will use appropriate record-keeping when caring for patients.
➢ The learner will understand the issues pertaining to consent to treatment and substitute decision making. (See also CanMEDS 2.)
➢ The learner will use the patient-centred clinical method to conduct a supervised office visit* for common presentations, which may include both symptoms and diagnoses. (See Appendix 1.)
  * The supervised office visit should include culturally sensitive, age-appropriate history-taking and focused physical examination; use of appropriate investigations; formulation of a diagnosis; and development of a management plan that involves allied health professionals, community supports, drug therapy (see Appendix 3), patient education, and follow-up management at an appropriate level for the student’s training.
➢ The learner will demonstrate the basic correct technique in common office procedural skills. (See Appendix 2.)
➢ The learner will show a basic understanding of a pharmacotherapeutic treatment approach to primary care conditions, considering, at an appropriate level, pharmacodynamics, pharmacokinetics, side effects, important drug interactions, dosages, and costs. (See Appendix 3.)
➢ The learner will demonstrate comfort in the use of non-pharmacologic modalities.
➢ The learner will demonstrate a general approach to palliative care issues.

THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN.
➢ The learner will appreciate the value of continuity of care for developing a deep knowledge of patients.
➢ The learner will demonstrate application of an ethical framework in the clinical decision-making process. (See also CanMEDS 5.)

THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.
➢ The learner will be able to identify what health-promotion and disease-prevention activities are appropriate to particular populations, using the Canadian Task Force A and B recommendations.
THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN.
➢ The learner will be able to carry out a patient-centred interview that will include the following:
  ➢ Recognition of the difference between illness and disease.
  ➢ Exploration of patients’ experiences of illness.
  ➢ Exploration of patients’ personal history and context.
  ➢ Shared decision-making/finding common ground.
  ➢ Patient education.
  ➢ Recognition of a range of approaches to collaborating with patients.
➢ The learner will demonstrate effective communication skills in data gathering.
➢ The learner will demonstrate sensitivity when asking patients intimate questions.
➢ The learner will understand the issues around consent to treatment and substitute decision making. (See also CanMEDS 1.)

THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN.
➢ The learner will recognise that the patient-physician relationship is central to the practice of family medicine.

THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.
➢ The learner will be able to demonstrate how to introduce health-promotion and disease-prevention activities into the clinical encounter.
CanMEDS 3—Collaborator

**THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.**

➢ The learner will be able to describe a population and work with a population to improve its health. (See also CanMEDS 5.)

**FAMILY MEDICINE IS COMMUNITY BASED.**

➢ The learner will understand the team approach in the care of ambulatory patients. Note: The team is a group of individuals who work toward the resolution of a patient problem. (See also CanMEDS 5.)

➢ The learner will demonstrate an understanding of the structure and function of the health care system, and of the role of the family physician and family medicine in this system. (See also CanMEDS 4.)

➢ The learner will demonstrate the ability to liaise with appropriate community resources in the care of a patient. (See also CanMEDS 5.)

➢ The learner will be able to formulate a written or verbal referral plan and justify this plan with respect to clarity, appropriateness, and succinctness.

➢ The learner will demonstrate knowledge of reportable illnesses, as defined in public health terms.

CanMEDS 4—Health Manager

**THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.**

➢ The learner will be able to describe some of the methodological and ethical issues related to screening healthy and at-risk populations.

**FAMILY MEDICINE IS COMMUNITY BASED.**

➢ The learner will demonstrate an understanding of the structure and function of the health care system, and of the role of the family physician and family medicine in this system. (See also CanMEDS 3.)
## CanMEDS 5—Advocate

| THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN. |
| ➢ The learner will be able to take a history that includes the non-biological determinants of health. |

| THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN. |
| ➢ The learner will demonstrate application of an ethical framework in the clinical decision-making process. (See also CanMEDS 1.) |
| ➢ The learner will demonstrate an understanding of the key components of a professional relationship. (See also CanMEDS 7.) |

| THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION. |
| ➢ The learner will be able to describe a population and work with a population to improve its health. (See also CanMEDS 3.) |
| ➢ The learner will be able to identify what health-promotion and disease-prevention activities are appropriate to particular populations, using the Canadian Task Force A and B recommendations. (See also CanMEDS 1.) |

| FAMILY MEDICINE IS COMMUNITY BASED. |
| ➢ The learner will understand the team approach in the care of ambulatory patients. (Note: The team is a group of individuals who work toward the resolution of a patient problem) (See also CanMEDS 3.) |
| ➢ The learner will understand the special needs of children and other vulnerable groups with respect to community resources. |
| ➢ The learner will demonstrate the ability to liaise with appropriate community resources in the care of a patient. |
| ➢ The learner will demonstrate an understanding of the range of activities and organisations that will promote the well-being of his or her patients (e.g., community agencies, self-help groups, advocacy). |
CanMEDS 6—Scholar

THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.
➢ The student will demonstrate self-directed life-long learning.
➢ The learner will be able to demonstrate evidence-based decision making to aid patients and him- or herself with clinical decisions.

CanMEDS 7—Professional

THE PATIENT-PHYSICIAN RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN.
➢ The learner will demonstrate an understanding of the key components of a professional relationship.
➢ The learner will reflect on his or her development as a physician.

THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.
➢ The learner will understand the patient, personal, and professional impact of medical error.
Appendix 1

Symptoms and Diagnoses or Reasons for Office Visits

Symptoms

Cardiovascular
- Chest pain (cardiac and non-cardiac)
- Edema
- Fainting spells
- Palpitations
- Syncope

Dermatological
- Rash/skin lesions

Ear, nose, and throat
- Earache
- Nasal congestion
- Sore ear
- Sore throat

Gastrointestinal
- Abdominal and pelvic pain, both acute and chronic
- Anal/rectal symptoms
- Anorexia
- Blood in stool
- Constipation
- Decreased appetite
- Diarrhoea
- Dyspepsia
- Heartburn
- Nausea and vomiting
- Weight loss

General
- Fatigue
- Preoperative assessment
- “Unwell” state

Genitourinary
- Blood in urine
- Dysuria
- Vaginal discharge/urethral discharge, including sexually transmitted infections/pelvic inflammatory disease

Geriatric
- Falls

Infectious disease
- Colds
- Fever
Mental health
• Anxiety
• Confusion
• Depression
• Grief
• Parenting issues
• Relationship problems

Musculoskeletal
• Back pain – acute and chronic
• Joint pain – including shoulder symptoms and knee pain
• Neck pain – acute and chronic
• Shoulder symptoms
• Soft-tissue injuries

Neurological
• Dizziness and vertigo
• Headache – migraine, tension, and medication-induced; cluster; post-traumatic; sinus; migraine equivalents
• Seizures – febrile and other

Ophthalmological
• Red eye

Respiratory
• Cough
• Shortness of breath
• Wheezing

Women’s health
• Breast lumps
• Menstrual irregularities, excessive vaginal bleeding, and dysmenorrhoea

Diagnoses or Reasons for Visit

Cardiovascular
• Anaemia
• Angina/ischemic heart disease
• Arrhythmia
• Cardiovascular disease (angina, risk factors)
• Congestive heart failure
• Deep vein thrombosis
• Hypercholesterolaemia
• Hypertension
• Peripheral vascular disease

Dermatological
• Acne
• Decubitus ulcers
• Eczema and other irritant/contact dermatitis
• Psoriasis
• Skin infections, including those from fungal and non-fungal causes
• Warts
Ear, nose, and throat
- Otitis media and otitis externa
- Pharyngitis – viral/streptococcal/monocytic
- Sinusitis

Endocrinological
- Diabetes – types I and II
- Thyroid disease

Gastrointestinal
- Gastroesophageal reflux disease/peptic ulcer disease/Non-ulcer dyspepsia
- Haemorrhoids
- Hepatitis
- Irritable bowel syndrome
- Ischaemic bowel disease
- Peptic ulcer disease

General
- Allergies and anaphylactic reactions
- Anaphylaxis
- Failure to thrive – childhood
- Growth and development
- Lacerations/cuts and abrasions
- Obesity
- Poisoning
- Smoking cessation
- Violence (child, elder, partner, sexual assault)
- Work-related injuries/illness
- Worried well

Genitourinary
- Benign prostatic hypertrophy
- Cystitis
- Incontinence
- Sexually transmitted infections
- Urinary tract infections

Infectious disease
- Human immunodeficiency virus counselling
- Immunisations
- Influenza

Mental health
- Adjustment disorder
- Alcohol withdrawal
- Delirium
- Dementia
- Depression and suicide
- Personality disorders
- Sleep disorders/insomnia
- Somatisation
- Substance abuse
Musculoskeletal
- Arthritis – gout, psoriasis, osteoarthritis, and rheumatoid arthritis
- Bursitis
- Fractures
- Gout
- Injuries
- Osteoporosis
- Sprains and strains

Neurological
- Cerebrovascular disease
- Parkinson’s disease
- Transient ischaemic attacks/reversible ischaemic neurologic deficit

Oncological
- Cancer (common types and presentations)
- Palliative care

Ophthalmological
- Cataracts

Respiratory
- Asthma
- Bronchitis
- Chronic obstructive pulmonary disease/emphysema
- Croup
- Pneumonia
- Upper respiratory tract infections

Women’s health
- Breast cancer
- Breastfeeding issues
- Contraception counselling
- Intrapartum care
- Menopause
- Postpartum care
- Pregnancy (diagnosis)
- Pregnancy (termination)
- Prenatal care (including maternal serum screening and human immunodeficiency virus counselling)
Appendix 2

Office Procedural Skills

(Nota: The degree of expertise that a student will be able to demonstrate for any one of these procedures depends on the learning context; the procedures are listed simply as a guide to the type and range of procedural skills appropriate for learning in a family practice setting.)

- Casting, simple – e.g., forearm, below-knee
- Cryotherapy – i.e., of warts or other suitably treated benign skin lesions
- Dressing changes
- Ear syringing
- Electrodesiccaton of lesions
- Glucometer testing
- Haemoccult testing
- Injections – subcutaneous, intradermal, intramuscular, and intravenous
- Intravenous line start-up
- Local anaesthesia
- Pap testing
- Pelvic and rectal exams
- Peripheral neuropathy testing (filament)
- Pneumatic otoscopy
- Proctoscopy/use of an anoscope
- Pulmonary function testing (office-based)
- Punch biopsy
- Sexually transmitted disease screening
- Sterile technique
- Suturing
- Taking vital signs (including the weight and measurement of an infant)
- Uncomplicated normal delivery of a baby
- Venipuncture
- Wound dressing
Appendix 3

Broad Drug Classes

- Allergy medications
- Analgesic medications
- Anti-angina medications
- Antibiotic therapy
- Anticoagulant medications
- Anticonvulsant medications
- Antidepressant medications
- Antihypertensive medications
- Antipsychotic/neuroleptic medications
- Anxiolytic medications
- Asthma and chronic obstructive pulmonary disease medications
- Cholesterol-lowering agents
- Compliance/adherence issues
- Congestive heart failure medications
- Constipation and diarrhoeal medications
- Contraceptive therapy
- Cough and cold therapy
- Dermatological therapy
- Dyspepsia medications
- Dysrhythmia medications
- Gout medications
- Herbal therapy
- Hormone therapy
- Hypnotics/sedatives
- Hypoglycaemic medications
- Irritable bowel syndrome medications
- Ischaemic bowel disease medications
- Migraine medications
- Mood-stabilising medication
- Osteoporosis medications
- Thyroid-replacement medications
- Vitamin/mineral therapy