

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Assessment Objectives for Certification in Family Medicine

2nd Edition

May 2020

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Preface to the Second Edition

Similar to the first edition, this second edition of the document formerly titled *Defining Competence for the Purposes of Certification by the College of Family Physicians of Canada: Evaluation Objectives in Family Medicine* describes the essential skills and observable competencies that are expected from residents at the end of their training, and as such, serves as a major guide to both in-training assessment and the content of the Certification Examination.

The original version of the document¹, published in 2010, was envisioned as a living document that would be updated and enhanced to respond to the evolving nature of family medicine practice. The Working Group on the Certification Process², which evolved into the Certification Process and Assessment Committee (CPAC)³, was tasked with the continuous maintenance of the document.

To minimize disruption on family medicine programs and residents, several updates made over the last five years have been coalesced and are all being released in this new edition.

The following changes and additions were made in this second edition:

1. **Renaming the document *Assessment Objectives for Certification in Family Medicine*** in English (The French name remains unchanged). This change reflects usage in English medical education literature, where training programs are evaluated for their efficacy, but individuals in those programs are assessed for competence.
2. **Six new priority topics.** The decision to add these new topics is based on responses to the 2014 validation survey, sent to 2,000 practicing family physicians across the country. Thus, we have grown from 99 to 105 priority topics, which now include: Chronic Pain, Heart Failure, Pain, Rash, Renal Failure, and Shortness of Breath.
3. **Updated key features for 16 existing mental health related priority topics** based on work completed by the Working Group on the Assessment of Competence in Mental Health⁴. Priority Topic name Substance Abuse was changed to Substance Use and Addiction, following a change in terminology.
4. **Changed French translation for 8 priority topic names**, based on changes in terminology and/or updates to their key features.
5. **Three supplementary documents** are now integrated into the Assessment Objectives document as appendices. These are:
 - Priority Topics and Key Features for Rural and Remote Family Medicine⁵

¹ *Defining competence for the purposes of certification by the College of Family Physicians of Canada: Evaluation Objectives in Family Medicine*: College of Family Physicians of Canada; 2010

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⁵ **Working Group on the Assessment of Competence in Rural and Remote Family Medicine**: Elaine Blau, MD; Garth Campbell, MD; Claudette Chase, MD; Paul Dhillon, MD; Brian Geller, MD; Fred Janke, MD; C. Stuart Johnston, MD; Mohamed Ravalía, MD; H el ene Rousseau, MD

- Priority Topics and Key Features for Intrapartum and Perinatal Care⁶
- Priority Topics and Key Features for Mental Health (other than those that overlap with the existing priority topics for family medicine)

These supplementary documents are available to be used as resources that can guide in-training assessment and design of learning opportunities for residents in family medicine residency programs.

A conscious choice has been made to keep the overall structure and purpose of this second edition the same as the first edition. We did not change Part I and Part II of the first edition. There are language choices from the first edition left unchanged for clarity purposes – for example the term “evaluation objectives” in Part I and Part II. We are aware that the whole document needs to be reviewed and its terminology revised and updated. The review will happen over time, but changes will only be made in five to seven-year cycles to minimize training program impacts and program resource implications.

As with the first edition, this second edition provides an extensive list of competencies in family medicine, extending far beyond the mere listing of important medical knowledge. We urge all readers to read (or re-read) and focus on Part 1, as its framing of what is important to assess, especially the overarching Skill Dimensions of Competence, remains crucial and relevant to the assessment of future family physicians today (namely, Clinical Reasoning, Selectivity, Patient-Centred Approach, Communication, Professionalism and Procedures).

We continue to describe competencies in terms of their most salient key features and observable behaviours. We emphasize that each competency is specific to the situation’s context and to the phases of the clinical encounter; furthermore, each competency is linked back to the appropriate skill dimensions reinforcing this essential relationship.

The CFPC’s 2018 Standards of Accreditation for Residency Programs in Family Medicine⁷ indicate that the goal of training is to produce a candidate who is competent to enter and adapt to the independent (i.e., unsupervised) practice of comprehensive family medicine⁸ anywhere in Canada.

Through continuous observational sampling, utilising the key features and reflection on a resident’s behaviours and performances, assessors need to be eventually satisfied that a resident displays competency in all six essential skill dimensions of family medicine. Besides in-training assessment, the College of Family Physicians of Canada will continue to use the document as a foundation for examination content.

Awarding Certification in the College of Family Physicians (CCFP) is the responsibility of the CFPC’s Board of Examinations and Certification. This decision is the end result of three discrete, but linked, decisions. The first is a candidate’s qualifying to sit the examination, either through the decision by a training program to recommend a resident as ready to sit the Certification Examination, or by meeting the requirements of the Practice Eligible Route. The second is obtaining a pass on the Certification Examination in Family Medicine. The third is successfully completing all post-examination requirements, either the requirements of their

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⁷ *Standards of Accreditation for Residency Programs in Family Medicine.* Mississauga, ON: College of Family Physicians of Canada; 2018

⁸ Comprehensive family medicine as defined by the *Family Medicine Professional Profile*, Mississauga, Ontario: College of Family Physicians of Canada; 2018

residency-training program or any practice eligible requirements set by the CFPC, within the Board of Examinations and Certification's prescribed timelines.

For further details about competence-based assessment and its components, please refer to the College's 2018 *Continuous Reflective Assessment for Training (CRAFT)* document⁹.

⁹ *Continuous Reflective Assessment for Training (CRAFT): A national programmatic assessment model for family medicine.* Mississauga, ON: College of Family Physicians of Canada; 2018

Priority Topics

New priority topics have been bolded and the ones with updated key features are marked by an asterisk. Topics with an updated translation into French are marked by (F).

- | | |
|---|--|
| 1. Abdominal Pain | 39. Fatigue |
| 2. Advanced Cardiac Life Support | 40. Fever |
| 3. Allergy | 41. Fractures |
| 4. Anemia | 42. Gastro-intestinal Bleed |
| 5. Antibiotics | 43. Gender Specific Issues (F) |
| 6. Anxiety* | 44. Grief* |
| 7. Asthma | 45. Headache |
| 8. Atrial Fibrillation | 46. Heart Failure |
| 9. Bad News | 47. Hepatitis |
| 10. Behavioural Problems* (F) | 48. Hyperlipidemia (F) |
| 11. Breast Lump | 49. Hypertension |
| 12. Cancer | 50. Immigrants |
| 13. Chest Pain | 51. Immunization |
| 14. Chronic Disease | 52. In Children |
| 15. Chronic Obstructive Pulmonary Disease | 53. Infections |
| 16. Chronic Pain | 54. Infertility |
| 17. Contraception | 55. Insomnia* |
| 18. Cough | 56. Ischemic Heart Disease |
| 19. Counselling* (F) | 57. Joint Disorder |
| 20. Crisis* | 58. Lacerations |
| 21. Croup (F) | 59. Learning (Patients/Self) (F) |
| 22. Deep Venous Thrombosis | 60. Lifestyle |
| 23. Dehydration | 61. Loss of Consciousness |
| 24. Dementia* | 62. Loss of Weight |
| 25. Depression* | 63. Low-back Pain |
| 26. Diabetes | 64. Meningitis |
| 27. Diarrhea | 65. Menopause |
| 28. Difficult Patient | 66. Mental Competency* (F) |
| 29. Disability | 67. Multiple Medical Problems |
| 30. Dizziness | 68. Neck Pain |
| 31. Domestic Violence | 69. Newborn |
| 32. Dyspepsia | 70. Obesity |
| 33. Dysuria | 71. Osteoporosis |
| 34. Earache | 72. Pain |
| 35. Eating Disorders* | 73. Palliative Care |
| 36. Elderly | 74. Parkinsonism |
| 37. Epistaxis | 75. Periodic Health Assessment/Screening |
| 38. Family Issues | 76. Personality Disorder* |

- 77. Pneumonia
- 78. Poisoning
- 79. Pregnancy
- 80. Prostate
- 81. Rape/Sexual Assault
- 82. Rash**
- 83. Red Eye
- 84. Renal Failure**
- 85. Schizophrenia*
- 86. Seizures
- 87. Sex* (F)
- 88. Sexually Transmitted Infections
- 89. Shortness of Breath**
- 90. Skin Disorder
- 91. Smoking Cessation
- 92. Somatization*
- 93. Stress
- 94. Stroke
- 95. Substance Use and Addiction*
- 96. Suicide*
- 97. Thyroid
- 98. Trauma
- 99. Travel Medicine
- 100. Upper Respiratory Tract Infection
- 101. Urinary Tract Infection
- 102. Vaginal Bleeding
- 103. Vaginitis
- 104. Violent/Aggressive Patient
- 105. Well-baby Care

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Abdominal Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a patient with abdominal pain, paying particular attention to its location and chronicity:		
a) Distinguish between acute and chronic pain.	<i>Clinical Reasoning</i>	<i>History</i>
b) Generate a complete differential diagnosis (ddx).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
c) Investigate in an appropriate and timely fashion.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Investigation</i>
2 In a patient with diagnosed abdominal pain (e.g., gastroesophageal reflux disease, peptic ulcer disease, ulcerative colitis, Crohn's disease), manage specific pathology appropriately (e.g., with medication, lifestyle modifications).	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 In a woman with abdominal pain:		<i>Hypothesis generation</i> <i>Investigation</i>
a) Always rule out pregnancy if she is of reproductive age.	<i>Clinical Reasoning</i>	<i>Investigation</i>
b) Suspect gynecologic etiology for abdominal pain.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
c) Do a pelvic examination, if appropriate.	<i>Clinical Reasoning</i>	<i>Physical</i> <i>Diagnosis</i>
4 In a patient with acute abdominal pain, differentiate between a surgical and a non-surgical abdomen.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Physical</i> <i>Diagnosis</i>
5 In specific patient groups (e.g., children, pregnant women, the elderly), include group-specific surgical causes of acute abdominal pain in the ddx.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
6 Given a patient with a life-threatening cause of acute abdominal pain (e.g., a ruptured abdominal aortic aneurysm or a ruptured ectopic pregnancy):		
a) Recognize the life-threatening situation.	<i>Selectivity</i>	<i>Diagnosis</i>
b) Make the diagnosis.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
c) Stabilize the patient.	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
d) Promptly refer the patient for definitive treatment.	<i>Selectivity</i>	<i>Diagnosis</i> <i>Referral</i>
7 In a patient with chronic or recurrent abdominal pain:		
a) Ensure adequate follow-up to monitor new or changing symptoms or signs.	<i>Clinical Reasoning</i>	<i>Follow-up</i>
b) Manage symptomatically with medication and lifestyle modification (e.g., for irritable bowel syndrome).	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Treatment</i>
c) Always consider cancer in a patient at risk.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
8 Given a patient with a diagnosis of inflammatory bowel disease (IBD) recognize an extra intestinal manifestation.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>

Advanced Cardiac Life Support

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Keep up to date with advanced cardiac life support (ACLS) recommendations (i.e., maintain your knowledge base).	<i>Professionalism</i>	<i>Treatment</i>
2 Promptly defibrillate a patient with ventricular fibrillation (V fib), or pulseless or symptomatic ventricular tachycardia (V tach).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Diagnose serious arrhythmias (V tach, V fib, supraventricular tachycardia, atrial fibrillation, or second- or third-degree heart block), and treat according to ACLS protocols.	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
4 Suspect and promptly treat reversible causes of arrhythmias (e.g., hyperkalemia, digoxin toxicity, cocaine intoxication) before confirmation of the diagnosis.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Treatment</i>
5 Ensure adequate ventilation (i.e., with a bag valve mask), and secure the airway in a timely manner.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
6 In patients requiring resuscitation, assess their circumstances (e.g., asystole, long code times, poor pre-code prognosis, living wills) to help you decide when to stop. (Avoid inappropriate resuscitation.)	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
7 In patients with serious medical problems or end-stage disease, discuss code status and end-of-life decisions (e.g., resuscitation, feeding tubes, levels of treatment), and readdress these issues periodically.	<i>Patient-centred Approach</i>	<i>Treatment Follow-up</i>
8 Attend to family members (e.g., with counselling, presence in the code room) during and after resuscitating a patient.	<i>Professionalism Communication</i>	<i>Treatment</i>
9 In a pediatric resuscitation, use appropriate resources (e.g., Braeslow tape, the patient's weight) to determine the correct drug doses and tube sizes.	<i>Clinical Reasoning</i>	<i>Treatment</i>

Note: Shock is not dealt with in this topic.

Allergy

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, always inquire about any allergy and clearly document it in the chart. Re-evaluate this periodically.	<i>Clinical Reasoning</i>	<i>History Follow-up</i>
2 Clarify the manifestations of a reaction in order to try to diagnose a true allergic reaction (e.g., do not misdiagnose viral rashes as antibiotic allergy, or medication intolerance as true allergy).	<i>Clinical Reasoning</i>	<i>History Diagnosis</i>
3 In a patient reporting allergy (e.g., to food, to medications, environmental), ensure that the patient has the appropriate medication to control symptoms (e.g., antihistamines, bronchodilators, steroids, an EpiPen).	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 Prescribe an EpiPen to every patient who has a history of, or is at risk for, anaphylaxis.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Educate appropriate patients with allergy (e.g., to food, medications, insect stings) and their families about the symptoms of anaphylaxis and the self-administration of the EpiPen, and advise them to return for immediate reassessment and treatment if those symptoms develop or if the EpiPen has been used.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment Follow-up</i>
6 Advise patients with any known drug allergy or previous major allergic reaction to get a MedicAlert bracelet.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
7 In a patient presenting with an anaphylactic reaction: <ul style="list-style-type: none"> a) Recognize the symptoms and signs. b) Treat immediately and aggressively. c) Prevent a delayed hypersensitivity reaction through observation and adequate treatment (e.g., with steroids). 	<i>Selectivity Clinical Reasoning</i> <i>Selectivity Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i> <i>Treatment</i>
8 In patients with anaphylaxis of unclear etiology refer to an allergist for clarification of the cause.	<i>Clinical Reasoning</i>	<i>Referral</i>
9 In the particular case of a child with an anaphylactic reaction to food: <ul style="list-style-type: none"> a) Prescribe an EpiPen for the house, car, school, and daycare. b) Advise the family to educate the child, teachers, and caretakers about signs and symptoms of anaphylaxis, and about when and how to use the EpiPen. 	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Treatment</i> <i>Treatment</i>
10 In a patient with unexplained recurrent respiratory symptoms, include allergy (e.g., sick building syndrome, seasonal allergy) in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis Generation</i>

Anemia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Assess the risk of decompensation of anemic patients (e.g., volume status, the presence of congestive heart failure [CHF], angina, or other disease states) to decide if prompt transfusion or volume replacement is necessary.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Treatment</i>
2 In a patient with anemia, classify the anemia as microcytic, normocytic, or macrocytic by using the MCV (mean corpuscular value) or smear test result, to direct further assessment and treatment.	<i>Clinical Reasoning</i>	<i>Diagnosis Investigation</i>
3 In all patients with anemia, determine the iron status before initiating treatment.	<i>Clinical Reasoning</i>	<i>Investigation Diagnosis</i>
4 In a patient with iron deficiency, investigate further to find the cause.	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 Consider and look for anemia in appropriate patients (e.g., those at risk for blood loss [those receiving anticoagulation, elderly patients taking a nonsteroidal anti-inflammatory drug]) or in patients with hemolysis (mechanical valves), whether they are symptomatic or not, and in those with new or worsening symptoms of angina or CHF.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis Generation Investigation</i>
6 In patients with macrocytic anemia: a) Consider the possibility of vitamin B ₁₂ deficiency. b) Look for other manifestations of the deficiency (e.g., neurologic symptoms) in order to make the diagnosis of pernicious anemia when it is present.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis Generation</i> <i>History Physical</i>
7 As part of well-baby care, consider anemia in high-risk populations (e.g., those living in poverty) or in high-risk patients (e.g., those who are pale or have a low-iron diet or poor weight gain).	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis Generation</i>
8 When a patient is discovered to have a slightly low hemoglobin level, look carefully for a cause (e.g., hemoglobinopathies, menorrhagia, occult bleeding, previously undiagnosed chronic disease), as one cannot assume that this is normal for them.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis Generation Diagnosis</i>
9 In anemic patients with menorrhagia, determine the need to look for other causes of the anemia.	<i>Clinical Reasoning</i>	<i>Hypothesis Generation</i>

Antibiotics

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients requiring antibiotic therapy, make rational choices (i.e., first-line therapies, knowledge of local resistance patterns, patient's medical and drug history, patient's context).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
2 In patients with a clinical presentation suggestive of a viral infection, avoid prescribing antibiotics.	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 In a patient with a purported antibiotic allergy, rule out other causes (e.g., intolerance to side effects, non-allergic rash) before accepting the diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis Generation History</i>
4 Use a selective approach in ordering cultures before initiating antibiotic therapy (usually not in uncomplicated cellulitis, pneumonia, urinary tract infections, and abscesses; usually for assessing community resistance patterns, in patients with systemic symptoms, and in immunocompromised patients).	<i>Selectivity</i>	<i>Investigation</i>
5 In urgent situations (e.g., cases of meningitis, septic shock, febrile neutropenia), do not delay administration of antibiotic therapy (i.e., do not wait for confirmation of the diagnosis).	<i>Selectivity</i>	<i>Treatment</i>

Anxiety

Key Feature	Skill	Phase
1 For a patient with multiple unexplained symptoms or behaviours, look for anxiety as a primary or contributing cause.	Clinical Reasoning Patient-centred Approach	Hypothesis Generation Diagnosis
2 When a patient presents with symptoms of anxiety, clearly distinguish between distress (e.g. fear, nervousness, worry) and an anxiety disorder.	Clinical Reasoning Patient-centred Approach	History Diagnosis
3 In a patient presenting with acute symptoms of panic (e.g., shortness of breath, palpitations, hyperventilation), do not attribute the symptoms to anxiety without first excluding serious medical pathology (e.g., pulmonary embolism, myocardial infarction) from the differential diagnosis, especially in patients with established anxiety disorder.	Selectivity Clinical Reasoning	Hypothesis Generation Diagnosis
4 When working up a patient with symptoms of anxiety, and before making the diagnosis of an anxiety disorder, a) Exclude serious medical pathology b) Identify: <ul style="list-style-type: none"> • other co-morbid psychiatric conditions • abuse • substance use c) Assess the risk of suicide d) Discuss functional impact with the patient	Selectivity Clinical reasoning Clinical reasoning Clinical reasoning Patient-centred Approach	Hypothesis generation Diagnosis History History History
5 When an anxiety disorder is suspected, assess and classify according to established diagnostic criteria, as treatment will vary according to the classification.	Clinical reasoning	Diagnosis
6 In patients with known anxiety disorders, do not assume all new symptoms are attributable to the anxiety disorder.	Selectivity Clinical reasoning	Hypothesis generation
7 When planning management of anxiety, offer appropriate treatment, which may include one or a combination of the following: <ul style="list-style-type: none"> + Self-management techniques + Regular office follow-up + Community resources + Structured therapies (Cognitive Behavioral Therapy, psychotherapy) + Judicious use of pharmacotherapy + Referral to other health professionals with ongoing shared care 	Patient-centred Approach	Treatment Referral
8 When managing anxiety or an anxiety disorder do not use medication as a sole treatment.	Patient-centred Approach Clinical reasoning	Treatment
9 When assessing and managing anxiety, discuss the use of alcohol and substances as harmful self-medication.	Patient-centred Approach Communication	Treatment

Atrial Fibrillation

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient who presents with new onset atrial fibrillation, look for an underlying cause (e.g., ischemic heart disease, acute myocardial infarction, congestive heart failure, cardiomyopathy, pulmonary embolus, hyperthyroidism, alcohol, etc.)	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 In a patient presenting with atrial fibrillation, a) Look for hemodynamic instability, b) Intervene rapidly and appropriately to stabilize the patient.	<i>Clinical Reasoning Selectivity</i> <i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i> <i>Treatment</i>
3 In an individual presenting with chronic or paroxysmal atrial fibrillation, a) Explore the need for anticoagulation based on the risk of stroke with the patient, b) Periodically reassess the need for anticoagulation.	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i> <i>Hypothesis generation</i> <i>Follow-up</i>
4 In patients with atrial fibrillation, when the decision has been made to use anticoagulation, institute the appropriate therapy and patient education, with a comprehensive follow-up plan.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
5 In a stable patient with atrial fibrillation, identify the need for rate control.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>
6 In a stable patient with atrial fibrillation, arrange for rhythm correction when appropriate.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i> <i>Treatment</i>

Bad News

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When giving bad news, ensure that the setting is appropriate, and ensure patient's confidentiality.	<i>Patient-centred Approach Communication</i>	<i>Treatment</i>
2 Give bad news: <ul style="list-style-type: none"> • in an empathic, compassionate manner • allowing enough time. • providing translation, as necessary 	<i>Communication</i>	<i>Treatment</i>
3 Obtain patient consent before involving the family.	<i>Patient-centred Approach Professionalism</i>	<i>Treatment</i>
4 After giving bad news, arrange definitive follow-up opportunities to assess impact and understanding.	<i>Patient-centred Approach Communication</i>	<i>Follow-up</i>

Behavioural Problems

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, when working up a behavioural problem, a) Ensure a thorough assessment of medical and mental health conditions (e.g., schizophrenia in adolescents and young adults) and psychosocial factors before offering a diagnosis or definitive advice (i.e., do not dismiss the problem as being “a phase,” or “hormones,” or “just adolescence”) b) Use a validated assessment tool if available c) Use multiple sources of information (e.g., workplace, family, school) with consent d) Explore the patient’s own perspective, not just that of the caregiver	<i>Clinical reasoning</i> <i>Patient-centred Approach</i> <i>Selectivity</i> <i>Clinical reasoning</i> <i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>History</i> <i>History</i> <i>Investigation</i> <i>History</i> <i>History</i>
2 In assessing behavioural problems in adolescents specifically look for substance use, peer issues, abuse, and other stressors.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i>
3 While assessing behavioural problems in a patient, a) Evaluate the impact of the behaviour b) Explore any underlying emotional distress with the patient c) Destigmatize embarrassing behaviours	<i>Clinical reasoning</i> <i>Patient-centred Approach</i> <i>Communication</i> <i>Patient-centred Approach</i> <i>Communication</i> <i>Patient-centred Approach</i>	<i>History</i> <i>History</i> <i>Treatment</i> <i>Treatment</i>
4 When making a diagnosis of a behavioural problem in a patient, a) Avoid premature labelling of a behaviour as a disorder b) Follow up with support and regular visits until the situation is clearer and any therapeutic requirements are more evident	<i>Clinical reasoning</i> <i>Clinical reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i> <i>Follow-up</i>
5 When managing behavioural problems: a) Assess and address immediate risk for the patient and others b) Do not limit treatment to medication; address other dimensions (e.g., do not just use amphetamines to treat ADD, but add social skills teaching, time management, etc.) and match to available community resources	<i>Patient-centred Approach</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Treatment</i>
6 When there is a challenging relationship with a patient with behavioural problems maintain a continuous, therapeutic, and non-judgmental relationship with the patient and family.	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Follow-up</i>

Breast Lump

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a well woman with concerns about breast disease, during a clinical encounter (annual or not):		
a) Identify high-risk patients by assessing modifiable and non-modifiable risk factors	<i>Clinical Reasoning Selectivity</i>	<i>History Diagnosis</i>
b) Advise regarding screening (mammography, breast self-examination) and its limitations.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
c) Advise concerning the woman's role in preventing or detecting breast disease (breast self-examination, lifestyle changes).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
2 Given a woman presenting with a breast lump (i.e., clinical features):		
a) Use the history, features of the lump, and the patient's age to determine (interpret) if aggressive work-up or watchful waiting is indicated.	<i>Selectivity Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
b) Ensure adequate support throughout investigation of the breast lump by availability of a contact resource.	<i>Patient-centred Approach Professionalism</i>	<i>Treatment Follow-up</i>
c) Use diagnostic tools (e.g., needle aspiration, imaging, core biopsy, referral) in an appropriate manner (i.e., avoid over- or under-investigation, misuse) for managing the breast lump.	<i>Clinical Reasoning</i>	<i>Investigation Treatment</i>
3 In a woman who presents with a malignant breast lump and knows the diagnosis:		
a) Recognize and manage immediate and long-term complications of breast cancer.	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
b) Consider and diagnose metastatic disease in the follow-up care of a breast cancer patient by appropriate history and investigation.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation History</i>
c) Appropriately direct (provide a link to) the patient to community resources able to provide adequate support (psychosocial support).	<i>Patient-centred Approach Clinical Reasoning</i>	<i>Follow-up Treatment</i>

Cancer

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, be opportunistic in giving cancer prevention advice (e.g., stop smoking, reduce unprotected sexual intercourse, prevent human papillomavirus infection), even when it is not the primary reason for the encounter.	<i>Patient-centred Approach Communication</i>	<i>Treatment</i>
2 In all patients, provide the indicated evidence-based screening (according to age group, risk factors, etc.) to detect cancer at an early stage (e.g., with Pap tests, mammography, colonoscopy, digital rectal examinations, prostate-specific antigen testing).	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis</i>
3 In patients diagnosed with cancer, offer ongoing follow-up and support and remain involved in the treatment plan, in collaboration with the specialist cancer treatment system. (Don't lose track of your patient during cancer care.)	<i>Patient-centred Approach Professionalism</i>	<i>Follow-up Treatment</i>
4 In a patient diagnosed with cancer, actively inquire, with compassion and empathy, about the personal and social consequences of the illness (e.g., family issues, loss of job), and the patient's ability to cope with these consequences.	<i>Patient-centred Approach Communication</i>	<i>History</i>
5 In a patient treated for cancer, actively inquire about side effects or expected complications of treatment (e.g., diarrhea, feet paresthesias), as the patient may not volunteer this information.	<i>Clinical Reasoning</i>	<i>History Follow-up</i>
6 In patients with a distant history of cancer who present with new symptoms (e.g., shortness of breath, neurologic symptoms), include recurrence or metastatic disease in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
7 In a patient diagnosed with cancer, be realistic and honest when discussing prognosis. (Say when you don't know.)	<i>Communication Professionalism</i>	<i>Treatment Follow-up</i>

Note: For pain control, see the key features on [chronic disease](#) and [palliative care](#). See also the key feature on [depression](#).

Chest Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a patient with undefined chest pain, take an adequate history to make a specific diagnosis (e.g., determine risk factors, whether the pain is pleuritic or sharp, pressure, etc.).	<i>Clinical Reasoning</i>	<i>History</i>
2 Given a clinical scenario suggestive of life-threatening conditions (e.g., pulmonary embolism, tamponade, dissection, pneumothorax), begin timely treatment (before the diagnosis is confirmed, while doing an appropriate work-up).	<i>Selectivity</i>	<i>Diagnosis Treatment</i>
3 In a patient with unexplained chest pain, rule out ischemic heart disease.*	<i>Clinical Reasoning</i>	<i>Selectivity Hypothesis generation Investigation</i>
4 Given an appropriate history of chest pain suggestive of herpes zoster infection, hiatal hernia, reflux, esophageal spasm, infections, or peptic ulcer disease: a) Propose the diagnosis.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
b) Do an appropriate work-up/follow-up to confirm the suspected diagnosis.	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 Given a suspected diagnosis of pulmonary embolism: a) Do not rule out the diagnosis solely on the basis of a test with low sensitivity and specificity.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
b) Begin appropriate treatment immediately.	<i>Selectivity</i>	<i>Treatment</i>

Chronic Disease

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with a diagnosed chronic disease who presents with acute symptoms, diagnose: <ul style="list-style-type: none"> • acute complications of the chronic disease (e.g., diabetic ketoacidosis). • acute exacerbations of the disease (e.g., asthma exacerbation, acute arthritis). • a new, unrelated condition. 	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 Regularly reassess adherence (compliance) to the treatment plan (including medications).	<i>Clinical Reasoning</i>	<i>History</i> <i>Follow-up</i>
3 In patients with chronic disease:		
a) Actively inquire about pain.	<i>Clinical Reasoning</i>	<i>History</i>
b) Treat appropriately by:	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Hypothesis generation</i>
<ul style="list-style-type: none"> • titrating medication to the patient's pain. • taking into account other treatments and conditions (e.g., watching for interactions). • considering non-pharmacologic treatment and adjuvant therapies. 		
4 In patients with chronic disease, actively inquire about:	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>History</i>
<ul style="list-style-type: none"> • the psychological impact of diagnosis and treatment. • functional impairment. • underlying depression or risk of suicide. • underlying substance abuse. 		
5 Given a non-compliant patient, explore the reasons why, with a view to improving future adherence to the treatment plan.	<i>Patient-centred Approach</i>	<i>History</i>

Chronic Obstructive Pulmonary Disease

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients presenting with symptoms of prolonged or recurrent cough, dyspnea, or decreased exercise tolerance, especially those who also have a significant smoking history, suspect the diagnosis of chronic obstructive pulmonary disease (COPD).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 When the diagnosis of COPD is suspected, seek confirmation with pulmonary function studies (e.g., FEV1).	<i>Clinical Reasoning</i>	<i>Investigation</i>
3 In patients with COPD, use pulmonary function tests periodically to document disease progression.	<i>Clinical Reasoning</i>	<i>Investigation Follow-up</i>
4 Encourage smoking cessation in all patients diagnosed with COPD.*	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
5 Offer appropriate vaccinations to patients diagnosed with COPD (e.g., influenza/pneumococcal vaccination).	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 In an apparently stable patient with COPD, offer appropriate inhaled medication for treatment (e.g., anticholinergics/bronchodilators if condition is reversible, steroid trial).	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 Refer appropriate patients with COPD to other health professionals (e.g., a respiratory technician or pulmonary rehabilitation personnel) to enhance quality of life.	<i>Clinical Reasoning</i>	<i>Referral</i>
8 When treating patients with acute exacerbations of COPD, rule out co-morbidities (e.g., myocardial infarction, congestive heart failure, systemic infections, anemia).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
9 In patients with end-stage COPD, especially those who are currently stable, discuss, document, and periodically re-evaluate wishes about aggressive treatment interventions.	<i>Patient-centred Approach Clinical Reasoning</i>	<i>Treatment Follow-up</i>

See also: [Smoking Cessation](#)

Chronic Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with chronic pain: a) Establish the etiology	<i>Clinical reasoning Selectivity</i>	<i>Diagnosis</i>
b) Reassess and periodically review the etiology (e.g., previously undisclosed abuse, evolution of the underlying cause)	<i>Clinical reasoning Selectivity</i>	<i>Diagnosis Follow-up</i>
c) Periodically look for potential comorbidities or complications, particularly mental illness and addictions	<i>Clinical reasoning</i>	<i>Hypothesis Follow-up</i>
2 In a patient with chronic pain who complains of significantly increased pain, search for an alternative etiology (e.g., malignancy, addiction, diversion) as you cannot assume that the original cause of the pain is the reason for the exacerbation.	<i>Clinical reasoning</i>	<i>Hypothesis Diagnosis</i>
3 In a patient in whom you did not make the initial diagnosis of chronic pain: a) Establish an effective relationship	<i>Clinical reasoning</i>	<i>Treatment</i>
b) Verify the diagnosis	<i>Clinical reasoning</i>	<i>Diagnosis</i>
c) Clarify goals of treatment and plans for management	<i>Patient-centred Approach</i>	<i>Treatment</i>
4 In managing a patient with chronic pain: a) Use shared decision-making	<i>Clinical reasoning Patient-centered approach</i>	<i>Treatment</i>
b) Engage other professionals in this care when appropriate	<i>Clinical reasoning Professionalism</i>	<i>Treatment Referral</i>
5 In a patient with chronic pain: a) Comprehensively document the assessment, plan, goals, and prescription details	<i>Communication</i>	<i>Follow-up</i>
b) Make the treatment plan appropriately accessible (e.g., to the patient, team members, emergency department, on-call doctors, pharmacy)	<i>Communication Professionalism</i>	<i>Follow-up</i>
6 When prescribing medications with abuse potential in a patient with chronic pain where you have no established relationship or insufficient records, be prudent in your prescribing (e.g., limit doses, document reasons, check for double doctoring). Do not simply provide or refuse to prescribe.	<i>Professionalism Selectivity</i>	<i>Diagnosis Treatment</i>
7 Use a written treatment contract with realistic consequences (e.g., limiting prescribed quantities/carries) when prescribing medications with abuse potential to a patient with chronic pain.	<i>Communication Professionalism</i>	<i>Treatment Follow-up</i>
8 When a patient with chronic pain has breached a contract: a) Manage your own emotions	<i>Professionalism</i>	<i>Treatment</i>
b) Address the possible impact on your staff and team	<i>Professionalism</i>	<i>Treatment</i>
c) Apply or judiciously amend the contract (e.g., not putting a patient into immediate withdrawal)	<i>Clinical reasoning Professionalism</i>	<i>Treatment</i>
9 In a patient with chronic pain and addiction who presents with a destabilization of behaviour, carefully identify the etiology and contributing factors to adapt your management plan.	<i>Clinical reasoning Patient-centred Approach</i>	<i>Hypothesis Treatment</i>

Contraception

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 With all patients, especially adolescents, young men, postpartum women, and perimenopausal women, advise about adequate contraception when opportunities arise.	<i>Patient-centred Approach Communication</i>	<i>Treatment</i>
2 In patients using specific contraceptives, advise of specific factors that may reduce efficacy (e.g., delayed initiation of method, illness, medications, specific lubricants).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
3 In aiding decision-making to ensure adequate contraception: <ul style="list-style-type: none"> a) Look for and identify risks (relative and absolute contraindications). b) Assess (look for) sexually transmitted disease exposure. c) Identify barriers to specific methods (e.g., cost, cultural concerns). d) Advise of efficacy and side effects, especially short-term side effects that may result in discontinuation. 	<i>Clinical Reasoning</i>	<i>History</i>
	<i>Clinical Reasoning Patient-centred Approach</i>	<i>History</i>
	<i>Patient-centred Approach Communication</i>	<i>History</i>
	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 In patients using hormonal contraceptives, manage side effects appropriately (i.e., recommend an appropriate length of trial, discuss estrogens in medroxyprogesterone acetate [Depo-Provera]).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 In all patients, especially those using barrier methods or when efficacy of hormonal methods is decreased, advise about post-coital contraception.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 In a patient who has had unprotected sex or a failure of the chosen contraceptive method, inform about time limits in post-coital contraception (emergency contraceptive pill, intrauterine device).	<i>Clinical Reasoning</i>	<i>Treatment</i>

Cough

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients presenting with an acute cough: a) Include serious causes (e.g., pneumothorax, pulmonary embolism [PE]) in the differential diagnosis. b) Diagnose a viral infection clinically, principally by taking an appropriate history. c) Do not treat viral infections with antibiotics. (Consider antiviral therapy if appropriate.)	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i>
	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 In pediatric patients with a persistent (or recurrent) cough, generate a broad differential diagnosis (e.g., gastroesophageal reflux disease [GERD], asthma, rhinitis, presence of a foreign body, pertussis).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 In patients with a persistent (e.g., for weeks) cough: a) Consider non-pulmonary causes (e.g., GERD, congestive heart failure, rhinitis), as well as other serious causes (e.g., cancer, PE) in the differential diagnosis. (Do not assume that the child has viral bronchitis). b) Investigate appropriately.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
	<i>Clinical Reasoning</i>	<i>Investigation</i>
4 Do not ascribe a persistent cough to an adverse drug effect (e.g., from an angiotensin-converting enzyme inhibitor) without first considering other causes.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
5 In smokers with persistent cough, assess for chronic bronchitis (chronic obstructive pulmonary disease) and make a positive diagnosis when it is present. (Do not just diagnose a smoker's cough.)	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>

Counselling

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When counselling a patient:		
a) Set clear therapeutic goals with the patient	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
b) Allow adequate time	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Treatment</i>
c) Evaluate your own skills (e.g., Does the problem exceed the limits of your abilities? Are you the right person and is this the right time to unpack the patient's concerns?)	<i>Professionalism</i>	<i>Treatment</i>
d) Recognize when you are approaching or exceeding boundaries (e.g., transference, counter-transference)	<i>Professionalism</i>	<i>Treatment</i>
e) Recognize when your beliefs or biases may interfere with counselling	<i>Professionalism</i>	<i>Treatment</i>
f) Remain aware of the risks of offering advice versus providing options	<i>Professionalism</i>	<i>Treatment</i>
g) Pay close attention to the quality of the therapeutic relationship and alliance	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>Follow-up</i>
2 For a patient who is considering or requesting referral for counselling/psychotherapy, clarify concerns and provide realistic information about the process and available resources (e.g., expectations, timing, frequency, costs, duration, homework, starting/ending the relationship if ineffective).	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Referral</i>

See also: [Crisis](#)

Crisis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a patient presents with acute emotional distress: a) Take the necessary time to assist the patient, even if they present unexpectedly b) Acknowledge their feelings and help them de-escalate c) Employ the therapeutic effect of conversation	Selectivity Communication Patient-centred Approach Clinical reasoning Communication	Hypothesis generation History Treatment Treatment
2 As part of your management of a patient facing a crisis: a) Identify your patient's personal resources for support (e.g., family, internal strength, friends) as part of your management of a patient facing a crisis. b) Offer appropriate community resources (e.g., counsellor) as part of your ongoing management of a patient with a crisis c) Negotiate a follow-up plan with the patient d) Be careful not to cross boundaries when treating a patient in crisis (e.g., lending money, providing appointments outside regular hours)	Clinical reasoning Patient-centred Approach Selectivity Patient-centred Approach Communication Patient-centred Approach Professionalism	History Treatment Treatment Referral Treatment Follow-up Treatment Hypothesis
3 When a patient presents with emotional distress or declares themselves in crisis: a) Carefully assess the risk of harm to themselves or others b) Ask your patient if there are others needing help associated with the crisis c) Act accordingly	Clinical reasoning Clinical reasoning Patient-centred Approach Clinical reasoning Selectivity	Diagnosis History Treatment Follow-up Diagnosis Treatment
4 Use psychoactive medication rationally to assist patients in crisis.	Clinical Reasoning Selectivity	Diagnosis Treatment
5 Inquire about unhealthy coping methods (e.g., drugs, alcohol, eating, gambling, violence, sloth, promiscuity) in your patients facing crisis.	Clinical Reasoning Professionalism	History
6 Prepare your practice environment for possible crises or disasters and include colleagues and staff in the planning for both medical and non-medical crises.	Professionalism	Hypothesis generation Treatment

7 When dealing with an unanticipated medical crisis (e.g., seizure, shoulder dystocia):		
a) Be calm and methodical	Professionalism Clinical reasoning	History Treatment
b) Assess the environment for needed and available resources (people, material)	Selectivity	Treatment
c) Ask for the help you need	Professionalism Communication	Treatment Referral
d) Take timely action as appropriate in the context of the situation (e.g., resuscitation in the waiting room of the clinic versus in the emergency department)	Clinical reasoning Selectivity	Treatment
8 In all patients, to identify possible previous crises and avoid re-traumatization during medical encounters:		
a) Be attentive to triggers for re-traumatization	Clinical reasoning Patient-centred Approach	Hypothesis generation Diagnosis
b) Recognize different manifestations of emotional distress	Clinical reasoning Patient-centred Approach	Diagnosis
c) Address as appropriate	Clinical reasoning Patient-centred Approach	Diagnosis Treatment

Croup

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with croup, a) Identify the need for respiratory assistance (e.g., assess ABCs, fatigue, somnolence, paradoxical breathing, in drawing) b) Provide that assistance when indicated.	Selectivity Clinical Reasoning Clinical Reasoning Selectivity	Hypothesis generation Diagnosis Treatment
2 Before attributing stridor to croup, consider other possible causes (e.g., anaphylaxis, foreign body (airway or esophagus), retropharyngeal abscess, epiglottitis).	Clinical Reasoning Selectivity	Hypothesis generation Diagnosis
3 In any patient presenting with respiratory symptoms, look specifically for the signs and symptoms that differentiate upper from lower respiratory disease (e.g., stridor vs. wheeze vs. whoop).	Clinical Reasoning	History Physical
4 In a child presenting with a clear history and physical examination compatible with mild to moderate croup, make the clinical diagnosis without further testing (e.g., do not routinely X-ray).	Clinical Reasoning Selectivity	Diagnosis Investigation
5 In patients with a diagnosis of croup, use steroids (do not under treat mild-to-moderate cases of croup).	Clinical Reasoning	Treatment
6 In a patient presenting with croup, address parental concerns (e.g., not minimizing the symptoms and their impact on the parents), acknowledging fluctuating course of the disease, providing a plan anticipating recurrence of the symptoms.	Clinical Reasoning Communication	Treatment Follow-up

Deep Venous Thrombosis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients complaining of leg pain and/or swelling, evaluate the likelihood of deep venous thrombosis (DVT) as investigation and treatment should differ according to the risk.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
2 In patients with high probability for thrombotic disease (e.g., extensive leg clot, suspected pulmonary embolism) start anticoagulant therapy if tests will be delayed.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Identify patients likely to benefit from DVT prophylaxis.	<i>Selectivity Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
4 Utilize investigations for DVT allowing for their limitations (e.g., Ultrasound and D-dimer).	<i>Clinical Reasoning Selectivity</i>	<i>Investigation Diagnosis</i>
5 In patients with established DVT use oral anticoagulation appropriately, (e.g., start promptly, watch for drug interactions, monitor lab values and adjust dose when appropriate, stop warfarin when appropriate, provide patient teaching).	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
6 Consider the possibility of an underlying coagulopathy in patients with DVT, especially when unexpected.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
7 Use compression stockings in appropriate patients, to prevent and treat post-phlebotic syndrome.	<i>Clinical Reasoning</i>	<i>Treatment</i>

Dehydration

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When assessing the acutely ill patient, look for signs and symptoms of dehydration. (e.g., look for dehydration in the patient with a debilitating pneumonia).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 In the dehydrated patient, assess the degree of dehydration using reliable indicators (e.g., vital signs) as some patients' hydration status may be more difficult to assess (e.g., elderly, very young, pregnant).	<i>Clinical Reasoning</i>	<i>Physical Investigation</i>
3 In a dehydrated patient, a) Determine the appropriate volume of fluid for replacement of deficiency and ongoing needs, b) Use the appropriate route (oral if the patient is able; IV when necessary).	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Treatment Diagnosis</i> <i>Treatment</i>
4 When treating severe dehydration, use objective measures (e.g., lab values) to direct ongoing management.	<i>Clinical Reasoning</i>	<i>Investigation Treatment</i>
5 In a dehydrated patient, a) Identify the precipitating illness or cause, especially looking for non-gastro-intestinal, including drug-related, causes, b) Treat the precipitating illness concurrently.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>
6 Treat the dehydrated pregnant patient aggressively, as there are additional risks of dehydration in pregnancy.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Treatment</i>

Dementia

Key Feature	Skill	Phase
1 In patients with early, non-specific signs of cognitive impairment: a) Suspect dementia as a diagnosis.	Clinical Reasoning	Hypothesis generation Diagnosis
b) Use validated tests of cognitive function and careful functional inquiry, as well as a careful history (including collateral history from family and caregivers if available) and physical examination, to make an early positive diagnosis.	Clinical Reasoning	Diagnosis
2 In patients with obvious cognitive impairment, a) Select proper laboratory investigations and neuroimaging techniques to complement the history and physical findings and to distinguish between dementia, delirium, and depression	Clinical reasoning	Investigation
b) Consider possible contributing causes, including mental health, alcohol or substance use problems, or delirium	Clinical reasoning	Hypothesis generation
3 In patients with dementia, distinguish Alzheimer's disease from other dementias, as treatment and prognosis differ.	Clinical Reasoning	Diagnosis
4 In patients with dementia who exhibit worsening function, look for other diagnoses (i.e., don't assume the dementia is worsening). These diagnoses may include depression, infection, concurrent medical illness, substance use, etc.	Clinical Reasoning	Hypothesis generation Diagnosis
5 When disclosing the diagnosis of dementia, a) Do so compassionately	Patient-centred Approach Communication	Diagnosis Treatment
b) Respect the patient's right to autonomy, confidentiality, and safety	Professionalism	Treatment
6 In patients with dementia, assess competency to involve them in decision making, as appropriate to the situation	Clinical Reasoning	Diagnosis Treatment
7 In following patients diagnosed with dementia: a) Assess function and cognitive impairment on an ongoing basis.	Clinical Reasoning	Follow-up Physical
b) Assist with and plan for appropriate interventions (e.g., deal with medication issues, behavioural disturbance management, safety issues, caregiver issues, comprehensive care plans, advanced care planning, driving safety, placement) in the context of disease progression	Clinical Reasoning Patient-centred Approach	Treatment
c) Manage comorbidities, including mental health problems based on the goals of care	Patient-centred Approach Clinical reasoning	Treatment
d) Review pharmacotherapy (e.g. side effects, drug interaction, polypharmacy)	Selectivity	Treatment
8 Assess the needs of and supports for caregivers of patients with dementia.	Patient-centred Approach	History

9 Report patients with dementia to the appropriate authorities if you suspect they should not be driving.	<i>Professionalism</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
10 In patients with early-onset dementia, consider genetic testing	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>History</i>

Depression

Key Feature	Skill	Phase
1 In a patient with a diagnosis of depression: a) Assess the patient for the risk of suicide	Clinical reasoning Communication	History Diagnosis
b) Decide on appropriate management (i.e., hospitalization or close follow-up, which will depend, for example, on severity of symptoms, psychotic features, and suicide risk)	Clinical Reasoning	Treatment
2 Identify patients who may be at a higher risk for depression (e.g., certain socio-economic groups, those who suffer from substance abuse, postpartum women, people with chronic pain) and assess appropriately.	Clinical reasoning	History
3 In patients who have medically unexplained symptoms consider and assess for depression.	Clinical reasoning Patient-centred Approach	Hypothesis generation History
4 After a diagnosis of depression is made look for and diagnose other comorbid psychiatric conditions (e.g., anxiety, bipolar disorder, personality disorder).	Clinical reasoning	Hypothesis generation Diagnosis
5 In a patient diagnosed with depression: a) Manage appropriately (e.g., medications, psychotherapy, supported self-management)	Clinical reasoning Patient-centred Approach	Treatment
b) Monitor their response to therapy and modify appropriately (e.g., augmentation, dose changes, medication changes)	Clinical reasoning	Treatment Follow-up
c) Reassess the patient's safety	Clinical reasoning	Follow-up
d) Set goals, including a return-to-work plan	Patient-centred Approach	Treatment
e) Refer as necessary (including community resources)	Clinical reasoning Patient-centred Approach	Referral
6 In a patient presenting with symptoms consistent with depression consider and rule out serious organic pathology using a targeted history, physical examination, and investigations (especially in elderly or difficult patients).	Clinical reasoning	Hypothesis generation History
7 In patients presenting with depression inquire about abuse: • Sexual, physical, and emotional abuse (past and current, witnessed or inflicted) • Addictions (e.g., substance use/abuse, gambling)	Clinical reasoning Selectivity	History
8 In a patient with symptoms of depression differentiate major depression from adjustment disorder, dysthymia, and a grief reaction.	Clinical reasoning	History Diagnosis
9 Following failure of an appropriate treatment in a patient with depression consider other diagnoses (e.g., bipolar disorder, schizoaffective disorder, organic disease).	Clinical reasoning	Hypothesis generation
10 In very young and elderly patients presenting with changes in	Clinical reasoning	Hypothesis generation

behaviour consider the diagnosis of depression (as they may not present with classic features).			
11	When treating a patient with antidepressants use them in a selective and careful manner, adapted to the presentation and the needs of the individual patient, by: <ul style="list-style-type: none"> • Selecting the most appropriate antidepressant and dose for the patient based on patient factors and on pharmacological factors (e.g., possible drug interactions) • Monitoring medication effectiveness, including adherence and the patient's possible self-medication using other substances (e.g., herbal and naturopathic remedies, alcohol, cannabis) • Considering augmentation strategies when appropriate • Monitoring side effects carefully when initiating treatment, especially in young and elderly patients • Discontinuing medication gradually, monitoring for relapse, recognizing risk, and following response 	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>History</i> <i>Treatment</i>
12	When developing a return-to-work plan for a patient who is being treated for depression: <ol style="list-style-type: none"> Assess the impact of residual symptoms on work hardiness, performance, and safety Communicate with the patient and the workplace to ensure the plan is realistic and provides clear guidance 	<i>Patient-centred Approach</i> <i>Selectivity</i>	<i>Treatment</i>
		<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>

Diabetes

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a symptomatic or asymptomatic patient at high risk for diabetes (e.g., patients with gestational diabetes, obese, certain ethnic groups, and those with a strong family history), screen at appropriate intervals with the right tests to confirm the diagnosis.	<i>Clinical Reasoning Selectivity</i>	<i>Investigation Hypothesis generation</i>
2 Given a patient diagnosed with diabetes, either new-onset or established, treat and modify treatment according to disease status (e.g., use oral hypoglycemic agents, insulin, diet, and/or lifestyle changes).	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
3 Given a patient with established diabetes, advise about signs and treatment of hypoglycemia/hyperglycemia during an acute illness or stress (i.e., gastroenteritis, physiologic stress, decreased intake).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
4 In a patient with poorly controlled diabetes, use effective educational techniques to advise about the importance of optimal glycemic control through compliance, lifestyle modification, and appropriate follow-up and treatment.	<i>Communication Patient-centred Approach</i>	<i>Treatment</i>
5 In patients with established diabetes: a) Look for complications (e.g., proteinuria).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
b) Refer them as necessary to deal with these complications	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
6 In the acutely ill diabetic patient, diagnose the underlying cause of the illness and investigate for diabetic ketoacidosis and hyperglycemia.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Treatment</i>
7 Given a patient with diabetic ketoacidosis, manage the problem appropriately and advise about preventing future episodes.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment Follow-up</i>

Diarrhea

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients with diarrhea, a) Determine hydration status, b) Treat dehydration appropriately.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 In patients with acute diarrhea, use history to establish the possible etiology (e.g., infectious contacts, travel, recent antibiotic or other medication use, common eating place for multiple ill patients).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>
3 In patients with acute diarrhea who have had recent hospitalization or recent antibiotic use, look for clostridium difficile.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
4 In patients with acute diarrhea, counsel about the timing of return to work/school (re: the likelihood of infectivity).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Pursue investigation, in a timely manner, of elderly with unexplained diarrhea, as they are more likely to have pathology.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Investigation</i>
6 In a young person with chronic or recurrent diarrhea, with no red flag symptoms or signs, use established clinical criteria to make a positive diagnosis of irritable bowel syndrome (do not overinvestigate).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i>
7 In patients with chronic or recurrent diarrhea, look for both gastro-intestinal and non-gastro-intestinal symptoms and signs suggestive of specific diseases (e.g., inflammatory bowel disease, malabsorption syndromes, and compromised immune system).	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i>

Difficult Patient

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When physician-patient interaction is deemed difficult, diagnose personality disorder when it is present in patients.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 When confronted with difficult patient interactions, seek out and update, when necessary, information about the patient's life circumstances, current context, and functional status.	<i>Patient-centred Approach</i>	<i>History Diagnosis</i>
3 In a patient with chronic illness, expect difficult interactions from time to time. Be especially compassionate and sensitive at those times.	<i>Patient-centred Approach Professionalism</i>	<i>Treatment Follow-up</i>
4 With difficult patients remain vigilant for new symptoms and physical findings to be sure they receive adequate attention (e.g., psychiatric patients, patients with chronic pain).	<i>Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
5 When confronted with difficult patient interactions, identify your own attitudes and your contribution to the situation.	<i>Professionalism</i>	<i>Treatment Diagnosis</i>
6 When dealing with difficult patients, set clear boundaries.	<i>Professionalism</i>	<i>Treatment</i>
7 Take steps to end the physician-patient relationship when it is in the patient's best interests.	<i>Professionalism Patient-centred Approach</i>	<i>Treatment</i>
8 With a difficult patient, safely establish common ground to determine the patient's needs (eg. threatening or demanding patients).	<i>Patient-centred Approach Professionalism</i>	<i>Treatment</i>

Disability

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Determine whether a specific decline in functioning (e.g., social, physical, emotional) is a disability for that specific patient.	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 Screen elderly patients for disability risks (e.g., falls, cognitive impairment, immobilization, decreased vision) on an ongoing basis.	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
3 In patients with chronic physical problems (e.g., arthritis, multiple sclerosis) or mental problems (e.g., depression), assess for and diagnose disability when it is present.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Diagnosis</i> <i>Hypothesis generation</i>
4 In a disabled patient, assess all spheres of function (emotional, physical, and social, the last of which includes finances, employment, and family).	<i>Patient-centred Approach</i>	<i>History</i>
5 For disabled patients, offer a multi-faceted approach (e.g., orthotics, lifestyle modification, time off work, community support) to minimize the impact of the disability and prevent further functional deterioration.	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Treatment</i>
6 In patients at risk for disability (e.g., those who do manual labour, the elderly, those with mental illness), recommend primary prevention strategies (e.g., exercises, braces, counselling, work modification).	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
7 Do not limit treatment of disabling conditions to a short-term disability leave (i.e., time off is only part of the plan).	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>

Dizziness

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients complaining of dizziness, rule out serious cardiovascular, cerebrovascular, and other neurologic disease (e.g., arrhythmia, myocardial infarction [MI], stroke, multiple sclerosis).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 In patients complaining of dizziness, take a careful history to distinguish vertigo, presyncope, and syncope.	<i>Clinical Reasoning</i>	<i>History</i>
3 In patients complaining of dizziness, measure postural vital signs.	<i>Clinical Reasoning Procedures Skills</i>	<i>Physical</i>
4 Examine patients with dizziness closely for neurologic signs.	<i>Clinical Reasoning Procedures Skills</i>	<i>Physical Hypothesis generation</i>
5 In hypotensive dizzy patients, exclude serious conditions (e.g., MI, abdominal aortic aneurysm, sepsis, gastrointestinal bleeding) as the cause.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
6 In patients with chronic dizziness, who present with a change in baseline symptoms, reassess to rule out serious causes.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
7 In a dizzy patient, review medications (including prescription and over-the-counter medications) for possible reversible causes of the dizziness.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
8 Investigate further those patients complaining of dizziness who have: <ul style="list-style-type: none"> • signs or symptoms of central vertigo. • a history of trauma. • signs, symptoms, or other reasons (e.g., anticoagulation) to suspect a possible serious underlying cause. 	<i>Selectivity</i>	<i>Investigation</i>

Domestic Violence

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with new, obvious risks for domestic violence, take advantage of opportunities in pertinent encounters to screen for domestic violence (e.g., periodic annual exam, visits for anxiety/depression, ER visits).	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>History</i>
2 In a patient in a suspected or confirmed situation of domestic violence: a) Assess the level of risk and the safety of children (i.e., the need for youth protection). b) Advise about the escalating nature of domestic violence.	<i>Selectivity</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Treatment</i>
3 In a situation of suspected or confirmed domestic violence, develop, in collaboration with the patient, an appropriate emergency plan to ensure the safety of the patient and other household members.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
4 In a patient living with domestic violence, counsel about the cycle of domestic violence and feelings associated with it (e.g., helplessness, guilt), and its impact on children.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>

Dyspepsia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with dyspepsia, include cardiovascular disease in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 Attempt to differentiate, by history and physical examination, between conditions presenting with dyspepsia (e.g., gastroesophageal reflux disease, gastritis, ulcer, cancer), as plans for investigation and management may be very different.	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i>
3 In a patient presenting with dyspepsia, ask about and examine the patient for worrisome signs/symptoms (e.g., gastrointestinal bleeding, weight loss, dysphagia).	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i>

Dysuria

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with dysuria, use history and dipstick urinalysis to determine if the patient has an uncomplicated urinary tract infection.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis</i>
2 When a diagnosis of uncomplicated urinary tract infection is made, treat promptly without waiting for a culture result.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Consider non-urinary tract infection related etiologies of dysuria (e.g., prostatitis, vaginitis, sexually transmitted disease, chemical irritation) and look for them when appropriate.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
4 When assessing patients with dysuria, identify those at higher risk of complicated urinary tract infection (e.g., pregnancy, children, diabetes, urolithiasis).	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i>
5 In patients with recurrent dysuria, look for a specific underlying cause (e.g., post-coital urinary tract infection, atrophic vaginitis, retention).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Earache

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Make the diagnosis of otitis media (OM) only after good visualization of the eardrum (i.e., wax must be removed), and when sufficient changes are present in the eardrum, such as bulging or distorted light reflex (i.e., not all red eardrums indicate OM).	<i>Clinical Reasoning</i> <i>Procedures Skills</i>	<i>Diagnosis</i> <i>Physical</i>
2 Include pain referred from other sources in the differential diagnosis of an earache (eg. Tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 Consider serious causes in the differential diagnosis of an earache (eg. tumors, temporal arteritis, mastoiditis).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
4 In the treatment of otitis media, explore the possibility of not giving antibiotics, thereby limiting their use (e.g., through proper patient selection and patient education because most otitis Media is of viral origin), and by ensuring good follow-up (e.g., reassessment in 48 hours).	<i>Selectivity</i> <i>Communication</i>	<i>Treatment</i>
5 Make rational drug choices when selecting antibiotic therapy for the treatment of otitis media. (Use first-line agents unless given a specific indication not to.)	<i>Selectivity</i> <i>Professionalism</i>	<i>Treatment</i>
6 In patients with earache (especially those with otitis media), recommend appropriate pain control (oral analgesics).	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 In a child with a fever and a red eardrum, look for other possible causes of the fever (i.e., do not assume that the red ear is causing the fever).*	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
8 Test children with recurrent ear infections for hearing loss.	<i>Clinical Reasoning</i>	<i>Investigation</i>

See also: [Fever](#)

Eating Disorders

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 During clinical encounters with children, adolescents, and young adults include an assessment of the risk of eating disorders, irrespective of the patient's gender, as this may be the only opportunity.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Hypothesis generation</i>
2 When caring for a patient with ongoing psychological distress or unexplained physical symptoms ask about body image and self-harm behaviours, including disordered eating.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Hypothesis generation</i>
3 In a patient for whom concerns about eating behaviours have been identified take an appropriate history, including: <ul style="list-style-type: none"> • Eating patterns, relationship with food, body image, distress • Underlying mental health, alcohol, and substance use problems, including previous psychological trauma • Use of prescribed and over-the-counter medications, tobacco, caffeine, laxatives, and supplements 	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i>
4 In a patient with disordered eating behaviour(s): <ol style="list-style-type: none"> a) Assess for physiological and metabolic complications b) Determine if there is a need for hospitalization or immediate intervention 	<i>Clinical reasoning</i> <i>Patient-centred Approach</i> <i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Physical Investigation</i> <i>Treatment</i>
5 When an eating disorder has been diagnosed: <ol style="list-style-type: none"> a) Discuss the impact and potential consequences, regardless of the patient's acceptance of the diagnosis b) Engage the parents/caregivers/partners in treatment when appropriate and with consent c) Collaborate with the patient and, when appropriate, family to develop a treatment plan, including an inter- and intra-professional referral when necessary d) Use simple cognitive behavioural intervention first (i.e., do not automatically assume tertiary care is needed) e) Periodically reassess behaviours and their impact on mood, anxiety, cognitive function, and relationships 	<i>Professionalism</i> <i>Patient-centred Approach</i> <i>Professionalism</i> <i>Patient-centred Approach</i> <i>Communication</i> <i>Patient-centred Approach</i> <i>Clinical reasoning</i> <i>Selectivity</i> <i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Treatment</i> <i>Treatment</i> <i>Referral</i> <i>Treatment</i> <i>Follow-up</i>
6 When assessing a patient presenting with a problem that has defied diagnosis (e.g., arrhythmias without cardiac disease, an electrolyte imbalance without drug use or renal impairment, amenorrhea without pregnancy) include "complication of an eating disorder" in the differential diagnosis.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i>

Elderly

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In the elderly patient taking multiple medications, avoid polypharmacy by: <ul style="list-style-type: none"> • monitoring side effects. • periodically reviewing medication (e.g., is the medication still indicated, is the dosage appropriate). • monitoring for interactions. 	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
2 In the elderly patient, actively inquire about non-prescription medication use (e.g., herbal medicines, cough drops, over-the-counter drugs, vitamins).	<i>Clinical Reasoning</i>	<i>History</i>
3 In the elderly patient, screen for modifiable risk factors (e.g., visual disturbance, impaired hearing) to promote safety and prolong independence.	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
4 In the elderly patient, assess functional status to: <ul style="list-style-type: none"> • anticipate and discuss the eventual need for changes in the living environment. • ensure that social support is adequate. 	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>History</i>
5 In older patients with diseases prone to atypical presentation, do not exclude these diseases without a thorough assessment (e.g., pneumonia, appendicitis, depression).	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>

Epistaxis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Through history and/or physical examination, assess the hemodynamic stability of patients with epistaxis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 While attending to active nose bleeds, recognize and manage excessive anxiety in the patient and accompanying family.	<i>Patient-centred Approach Clinical Reasoning</i>	<i>Treatment Diagnosis</i>
3 In a patient with an active or recent nosebleed, obtain a focused history to identify possible etiologies (e.g., recent trauma, recent upper respiratory infection, medications).	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
4 In a patient with an active or recent nosebleed, a) Look for and identify anterior bleeding sites, b) Stop the bleeding with appropriate methods.	<i>Clinical Reasoning</i> <i>Clinical Reasoning Procedures Skills</i>	<i>Physical</i> <i>Treatment</i>
5 In a patient with ongoing or recurrent bleeding in spite of treatment, consider a posterior bleeding site.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
6 In a patient with a nosebleed, obtain lab work only for specific indications (e.g., unstable patient, suspicion of a bleeding diathesis, use of anticoagulation)	<i>Clinical Reasoning Selectivity</i>	<i>Investigation Hypothesis generation</i>
7 In a patient with a nosebleed, provide thorough aftercare instructions (e.g., how to stop a subsequent nose bleed, when to return, humidification, etc.)	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>

Family Issues

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Routinely ask about family issues to understand their impact on the patient's illness and the impact of the illness on the family.	<i>Patient-centred Approach</i>	<i>History</i>
2 Ask about family issues <ul style="list-style-type: none"> • periodically • at important life-cycle points (e.g., when children move out, after the birth of a baby) • when faced with problems not resolving in spite of appropriate therapeutic interventions (e.g. medication compliance, fibromyalgia, hypertension) 	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>

Fatigue

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients complaining of fatigue, include depression in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 Ask about other constitutional symptoms as part of a systematic approach to rule out underlying medical causes in all patients complaining of fatigue.	<i>Clinical Reasoning</i>	<i>History</i>
3 Exclude adverse effects of medication as the cause in all patients complaining of fatigue.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
4 Avoid early, routine investigations in patients with fatigue unless specific indications for such investigations are present.	<i>Selectivity</i>	<i>Investigation</i>
5 Given patients with fatigue in whom other underlying disorders have been ruled out, assist them to place, in a therapeutic sense, the role of their life circumstances in their fatigue.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
6 In patients whose fatigue has become chronic, manage supportively, while remaining vigilant for new diseases and illnesses.	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>

Fever

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In febrile infants 0-3 months old: a) Recognize the risk of occult bacteremia.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
b) Investigate thoroughly (e.g., blood cultures, urine, lumbar puncture +/- chest X-ray).	<i>Clinical Reasoning</i>	<i>Investigation</i>
2 In a febrile patient with a viral infection, do NOT prescribe antibiotics.	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 In a febrile patient requiring antibiotic therapy, prescribe the appropriate antibiotic(s) according to likely causative organism(s) and local resistance patterns.	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 Investigate patients with fever of unknown origin appropriately (e.g., with blood cultures, echocardiography, bone scans).	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 In febrile patients, consider life-threatening infectious causes (e.g., endocarditis, meningitis).	<i>Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
6 Aggressively and immediately treat patients who have fever resulting from serious causes before confirming the diagnosis, whether these are infectious (e.g., febrile neutropenia, septic shock, meningitis) or non-infectious (e.g., heat stroke, drug reaction, malignant neuroleptic syndrome).	<i>Selectivity</i>	<i>Treatment</i>
7 In the febrile patient, consider causes of hyperthermia other than infection (e.g., heat stroke, drug reaction, malignant neuroleptic syndrome).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
8 In an elderly patient, be aware that no good correlation exists between the presence or absence of fever and the presence or absence of serious pathology.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Fractures

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with multiple injuries, stabilize the patient (e.g., airway, breathing, and circulation, and life-threatening injuries) before dealing with any fractures.	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 When examining patients with a fracture, assess neurovascular status and examine the joint above and below the injury.	<i>Clinical Reasoning</i>	<i>Physical</i>
3 In patients with suspected fractures that are prone to have normal X-ray findings (e.g., scaphoid fractures in wrist injuries, elbow fracture, growth plate fracture in children, stress fractures), manage according to your clinical suspicion, even if X-ray	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
4 In assessing elderly patients with an acute change in mobility (i.e., those who can no longer walk) and equivocal X-ray findings (e.g., no obvious fracture), investigate appropriately (e.g., with bone scans, computed tomography) before excluding a fracture.	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 Identify and manage limb injuries that require urgent immobilization and/or reduction in a timely manner.	<i>Selectivity</i>	<i>Treatment Diagnosis</i>
6 In assessing patients with suspected fractures, provide analgesia that is timely (i.e., before X-rays) and adequate (e.g., narcotic) analgesia.	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 In patients presenting with a fracture, look for and diagnose high-risk complications (e.g., an open fracture, unstable cervical spine, compartment syndrome).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
8 Use clinical decision rules (e.g., Ottawa ankle rules, C-spine rules, and knee rules) to guide the use of X-ray examinations.	<i>Clinical Reasoning Selectivity</i>	<i>Investigation</i>

Note: These key features do not include technical and or psychomotor skills such as casting, reduction of dislocations, etc. See [Procedural Skills](#).

Gastro-intestinal Bleed

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with blood in the stools who is hemodynamically stable, use history to differentiate upper vs. lower gastro-intestinal (GI) bleed as the investigation differs.	<i>Clinical Reasoning</i>	<i>Diagnosis History</i>
2 In a patient with suspected blood in the stool, explore other possible causes (e.g., beet ingestion, iron, Pepto-Bismol) before doing extensive investigation.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
3 Look for patients at higher risk for GI bleed (e.g., previous GI bleed, intensive care unit admission, nonsteroidal anti-inflammatory drugs, alcohol) so as to modify treatment to reduce risk of GI bleed (e.g. cytoprotection).	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
4 In a patient with obvious GI bleeding, identify patients who may require timely treatment even though they are not yet in shock.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
5 In a stable patient with lower GI bleeding, look for serious causes (e.g., malignancy, inflammatory bowel disease, ulcer, varices) even when there is an apparent obvious cause for the bleeding (e.g., do not attribute a rectal bleed to hemorrhoids or to oral anticoagulation).	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i>
6 In a patient with an upper GI bleed, a) Include variceal bleeding in your differential,	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
b) Use history and physical examination to assess the likelihood of a variceal bleed as its management differs.	<i>Clinical Reasoning</i>	<i>History Physical</i>

Gender Specific Issues

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In the assessment of clinical problems that might present differently in men and women, maintain an inclusive differential diagnosis that allows for these differences (e.g., women with coronary artery disease, depression in males).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 As part of caring for women with health concerns, assess the possible contribution of domestic violence.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>
3 When men and women present with stress-related health concerns, assess the possible contribution of role-balancing issues (e.g., work-life balance or between partners).	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>
4 Establish office policies and practices to ensure patient comfort and choice, especially with sensitive examinations (e.g., positioning for Pap, chaperones for genital/rectal exams).	<i>Professionalism</i>	<i>Physical</i>
5 Interpret and apply research evidence for your patients in light of gender bias present in clinical studies (e.g., ASA use in women).	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Hypothesis generation</i>

Grief

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients who have experienced a loss prepare them for the types of reactions (e.g., emotional, physical, varying length) they may have.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
2 In all grieving patients, especially those with a prolonged or complex grief reaction: a) Inquire about depression, suicidal ideation, self-medication, and alcohol and substance use b) Consider the requirement for additional treatments or referral	<i>Clinical reasoning</i> <i>Clinical reasoning</i>	<i>History</i> <i>Hypothesis generation</i> <i>Treatment</i>
3 Recognize that grief reactions may vary based on the individual's context and experiences; life cycle and developmental stages; and cultural and family contexts.	<i>Patient-centred Approach</i>	<i>Hypothesis generation</i>
4 In patients with presentations suggestive of grief reactions without obvious triggers look for triggers that may be unique to each patient (e.g., death of a pet, loss of a job, reactions to anniversary).	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Hypothesis generation</i>
5 In patients with unexplained or unresponsive physical or mental health concerns; alcohol or substance use; or functional or behavioural change ask about loss and/or grief as possible contributing factors.	<i>Clinical reasoning</i>	<i>History</i> <i>Hypothesis generation</i>

Headache

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a patient with a new-onset headache, differentiate benign from serious pathology through history and physical examination.	<i>Selectivity</i>	<i>History</i> <i>Physical</i>
2 Given a patient with worrisome headache suggestive of serious pathology (e.g., meningitis, tumour, temporal arteritis, subarachnoid bleed): a) Do the appropriate work-up (e.g., biopsy, computed tomography [CT], lumbar puncture [LP], erythrocyte sedimentation rate). b) Make the diagnosis. c) Begin timely appropriate treatment (i.e., treat before a diagnosis of temporal arteritis or meningitis is confirmed). d) Do not assume that relief of symptoms with treatment excludes serious pathology.	<i>Selectivity</i> <i>Clinical Reasoning</i> <i>Selectivity</i> <i>Clinical Reasoning</i> <i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Investigation</i> <i>Diagnosis</i> <i>Treatment</i> <i>Diagnosis</i>
3 Given a patient with a history of chronic and/or relapsing headache (e.g., tension, migraine, cluster, narcotic-induced, medication-induced), treat appropriately, and avoid narcotic, barbiturate dependence.	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 In a patient with a history of suspected subarachnoid bleed and a negative CT scan, do a lumbar puncture.	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Investigation</i>
5 In a patient suffering from acute migraine headache: a) Treat the episode. b) Assess the ongoing treatment plan. (referral when necessary, take a stepwise approach).	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Treatment</i> <i>Referral</i>

Heart Failure

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with newly diagnosed heart failure determine the underlying cause, as treatment will differ.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis</i> <i>Diagnosis</i>
2 In an older patient presenting with fatigue include heart failure in your differential diagnosis.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis</i>
3 In a patient with symptoms suggestive of heart failure and a normal ejection fraction do not exclude this diagnosis.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis</i> <i>Diagnosis</i>
4 In patients with heart failure periodically assess functional impairment using validated tools (e.g., New York Heart Association class, activities of daily living).	<i>Clinical reasoning</i>	<i>History</i> <i>Follow-up</i>
5 To guide your management of a patient with an exacerbation of heart failure: a) Identify possible triggers (e.g., infection, arrhythmia, adherence, diet, ischemia) b) Consider comorbid conditions (e.g., renal failure)	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis</i>
6 When treating heart failure: a) Identify the type of heart failure (e.g., systolic, diastolic) because the treatment is different b) Appropriately prescribe medications to reduce mortality as well as treat the symptoms of congestive failure (e.g., diuretics, beta-blockers, ACE inhibitors, digoxin)	<i>Clinical reasoning</i> <i>Selectivity</i> <i>Clinical reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Treatment</i> <i>Follow-up</i>
7 For patients with heart failure ensure you offer patient education and self-monitoring, such as routine self-weighing, healthy diet, medication adherence, smoking cessation, and exercise, to minimize exacerbations.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
8 In a patient with heart failure recognize non-sustained response to treatment as an indicator of worsening prognosis.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Follow-up</i>
9 In a patient with heart failure and a progressively deteriorating clinical course: a) Provide a realistic prognosis to patients and families b) Introduce palliative care principles when appropriate for the patient	<i>Clinical reasoning</i> <i>Communication</i> <i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Treatment</i>

Hepatitis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with hepatitis symptoms and/or abnormal liver function tests, take a focused history to assist in establishing the etiology (e.g., new drugs, alcohol, blood or body fluid exposure, viral hepatitis).	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
2 In a patient with abnormal liver enzyme tests interpret the results to distinguish between obstructive and hepatocellular causes for hepatitis as the subsequent investigation differs.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
3 In a patient where an obstructive pattern has been identified, a) Promptly arrange for imaging, b) Refer for more definitive management in a timely manner.	<i>Clinical Reasoning Selectivity</i>	<i>Investigation</i> <i>Treatment</i> <i>Referral</i>
4 In patients positive for Hepatitis B and/or C, a) Assess their infectiousness, b) Determine human immunodeficiency virus status.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Investigation</i> <i>Hypothesis generation</i> <i>Investigation</i>
5 In patients who are Hepatitis C antibody positive determine those patients who are chronically infected with Hepatitis C, because they are at greater risk for cirrhosis and hepatocellular cancer.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Investigation</i>
6 In patients who are chronically infected with Hepatitis C, refer for further assessment and possible treatment.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
7 In patients who are at risk for Hepatitis B and/or Hepatitis C exposure, a) Counsel about harm reduction strategies, risk of other blood borne diseases, b) Vaccinate accordingly.	<i>Patient-centred Approach</i> <i>Communication</i> <i>Clinical Reasoning</i>	<i>Treatment</i> <i>Treatment</i>
8 Offer post-exposure prophylaxis to patients who are exposed or possibly exposed to Hepatitis A or B.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Hypothesis generation</i>
9 Periodically look for complications (e.g., cirrhosis, hepatocellular cancer) in patients with chronic viral hepatitis, especially hepatitis C infection.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Follow-up</i>

Hyperlipidemia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Screen appropriate patients for hyperlipidemia.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
2 In all patients whose cardiovascular risk is being evaluated, include the assessment of lipid status.	<i>Clinical Reasoning</i>	<i>Investigation</i>
3 When hyperlipidemia is present, take an appropriate history, and examine and test the patient for modifiable causes (e.g., alcohol abuse, thyroid disease).	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
4 Ensure that patients diagnosed with hyperlipidemia receive appropriate lifestyle and dietary advice. Periodically reassess compliance with this advice (especially in patients at overall low or moderate CV risk).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment Follow-up</i>
5 In treating hyperlipidemic patients, establish target lipid levels based on overall CV risk.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
6 In patients receiving medication for hyperlipidemia, periodically assess compliance with and side effects of treatment.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment Follow-up</i>

Hypertension

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Screen for hypertension.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Physical</i>
2 Use correct technique and equipment to measure blood pressure.	<i>Procedures Skills</i>	<i>Physical</i>
3 Make the diagnosis of hypertension only after multiple BP readings (i.e., at different times and during different visits).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
4 In patients with an established diagnosis of hypertension, assess and re-evaluate periodically the overall cardiovascular risk and end-organ complications: a) Take an appropriate history. b) Do the appropriate physical examination. c) Arrange appropriate laboratory investigations.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i> <i>Investigation</i>
5 In appropriate patients with hypertension (e.g., young patients requiring multiple medications, patients with an abdominal bruit, patients with hypokalemia in the absence of diuretics): a) Suspect secondary hypertension. b) Investigate appropriately.	<i>Selectivity Clinical Reasoning</i> <i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i> <i>Investigation Treatment</i>
6 Suggest individualized lifestyle modifications to patients with hypertension. (e.g., weight loss, exercise, limit alcohol consumption, dietary changes).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
7 In a patient diagnosed with hypertension, treat the hypertension with appropriate pharmacologic therapy (e.g., consider the patient's age, concomitant disorders, other cardiovascular risk factors).	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 Given a patient with the signs and symptoms of hypertensive urgency or crisis, make the diagnosis and treat promptly.	<i>Selectivity</i>	<i>Diagnosis Treatment</i>
9 In all patients diagnosed with hypertension, assess response to treatment, medication compliance, and side effects at follow-up visits.	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Immigrants

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 As part of the periodic health assessment of newly arrived immigrants: a) Assess vaccination status (as it may not be up to date). b) Provide the necessary vaccinations to update their status.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>History</i> <i>Treatment</i>
2 As part of the ongoing care of immigrants, modify your approach (when possible) as required by their cultural context (e.g., history given only by husband, may refuse examination by a male physician, language barriers).	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>History</i>
3 When dealing with a language barrier, make an effort to obtain the history with the help of a medical interpreter and recognize the limitations of all interpreters (e.g., different agendas, lack of medical knowledge, something to hide).	<i>Communication</i>	<i>History</i>
4 As part of the ongoing care of all immigrants (particularly those who appear not to be coping): a) Screen for depression (i.e., because they are at higher risk and frequently isolated). b) Inquire about a past history of abuse or torture. c) Assess patients for availability of resources for support (e.g., family, community organizations).	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>History</i> <i>History</i>
5 In immigrants presenting with a new or ongoing medical condition, consider in the differential diagnosis infectious diseases acquired before immigration (e.g., malaria, parasitic disease, tuberculosis).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i>
6 As part of the ongoing care of all immigrants, inquire about the use of alternative healers, practices, and/or medications (e.g., “natural” or herbal medicines, spiritual healers, medications from different countries, moxibustion).	<i>Clinical Reasoning</i>	<i>History</i>

Immunization

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Do not delay immunizations unnecessarily (e.g., vaccinate a child even if he or she has a runny nose).	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 With parents who are hesitant to vaccinate their children, explore the reasons, and counsel them about the risks of deciding against routine immunization of their children.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>History</i>
3 Identify patients who will specifically benefit from immunization (e.g., not just the elderly and children, but also the immunosuppressed, travellers, those with sickle cell anemia, and those at special risk for pneumonia and hepatitis A and B), and ensure it is offered.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Hypothesis generation</i>
4 Clearly document immunizations given to your patients.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
5 In patients presenting with a suspected infectious disease, assess immunization status, as the differential diagnosis and consequent treatment in unvaccinated patients is different.	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
6 In patients presenting with a suspected infectious disease, do not assume that a history of vaccination has provided protection against disease (e.g., pertussis, rubella, diseases acquired while travelling).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i>

In Children

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When evaluating children, generate a differential diagnosis that accounts for common medical problems, which may present differently in children (e.g., urinary tract infections, pneumonia, appendicitis, depression).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 As children, especially adolescents, generally present infrequently for medical care, take advantage of visits to ask about: <ul style="list-style-type: none"> • un verbalized problems (e.g., school performance) • social well-being (e.g., relationships, home, friends) • modifiable risk factors (e.g., exercise, diet) • risk behaviours (e.g., use of bike helmets and seatbelts). 	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Treatment</i>
3 At every opportunity, directly ask questions about risk behaviours (e.g., drug use, sex, smoking, driving) to promote harm reduction.	<i>Clinical Reasoning</i> <i>Communication</i>	<i>History</i> <i>Treatment</i>
4 In adolescents, ensure the confidentiality of the visit, and, when appropriate, encourage open discussion with their caregivers about specific problems (e.g., pregnancy, depression and suicide, bullying, drug abuse).	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
5 In assessing and treating children, use age-appropriate language.	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>History</i>
6 In assessing and treating children, obtain and share information with them directly (i.e., don't just talk to the parents).	<i>Communication</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Treatment</i>
7 When investigation is appropriate, do not limit it because it may be unpleasant for those involved (the child, parents, or health care providers).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i> <i>Investigation</i>

Infections

Key Feature	Skill	Phase
1 In patients with a suspected infection, a) Determine the correct tools (e.g., swabs, culture/transport medium), techniques, and protocols for cultures, b) Culture when appropriate (e.g., throat swabs/sore throat guidelines).	Clinical Reasoning Clinical Reasoning Selectivity	Investigation Investigation
2 When considering treatment of an infection with an antibiotic, do so a) Judiciously (e.g., delayed treatment in otitis media with comorbid illness in acute bronchitis), b) Rationally (e.g., cost, guidelines, comorbidity, local resistance patterns).	Clinical Reasoning Selectivity Clinical Reasoning Selectivity	Treatment Treatment
3 Treat infections empirically when appropriate (e.g., in life threatening sepsis without culture report or confirmed diagnosis, candida vaginitis post-antibiotic use).	Clinical Reasoning Selectivity	Treatment
4 Look for infection as a possible cause in a patient with an ill-defined problem (e.g., confusion in the elderly, failure to thrive, unexplained pain [necrotizing fasciitis, abdominal pain in children with pneumonia]).	Clinical Reasoning	Hypothesis generation
5 When a patient returns after an original diagnosis of a simple infection and is deteriorating or not responding to treatment, think about and look for more complex infection. (i.e., When a patient returns complaining they are not getting better, don't assume the infection is just slow to resolve).	Clinical Reasoning	Hypothesis generation
6 When treating infections with antibiotics use other therapies when appropriate (e.g., aggressive fluid resuscitation in septic shock, incision and drainage abscess, pain relief).	Clinical Reasoning	Treatment

Infertility

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a patient consults you with concerns about difficulties becoming pregnant: a) Take an appropriate history (e.g., ask how long they have been trying, assess menstrual history, determine coital frequency and timing) before providing reassurance or investigating further. b) Ensure follow-up at an appropriate time (e.g., after one to two years of trying; in general, do not investigate infertility too early).	Clinical Reasoning	History
	Clinical Reasoning	Treatment
2 In patients with fertility concerns, provide advice that accurately describes the likelihood of fertility.	Clinical Reasoning	Treatment
3 With older couples who have fertility concerns, refer earlier for investigation and treatment, as their likelihood of infertility is higher.	Clinical Reasoning Selectivity	Hypothesis generation Referral
4 When choosing to investigate primary or secondary infertility, ensure that both partners are assessed.	Clinical Reasoning	Hypothesis generation
5 In couples who are likely infertile, discuss adoption when the time is right. (Remember that adoption often takes a long time.)	Patient-centred Approach Clinical Reasoning	Treatment
6 In evaluating female patients with fertility concerns and menstrual abnormalities, look for specific signs and symptoms of certain conditions (e.g., polycystic ovarian syndrome, hyperprolactinemia, thyroid disease) to direct further investigations (e.g., prolactin, thyroid-stimulating hormone, and luteal phase progesterone testing).	Clinical Reasoning	Hypothesis generation History

Insomnia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients presenting with sleep complaints take a careful history to distinguish insomnia from specific psychiatric diagnoses or other sleep-related diagnoses (e.g., sleep apnea, periodic limb movements, restless legs syndrome, sleepwalking, sleep talking).	<i>Clinical reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
2 When assessing patients with sleep complaints: <ul style="list-style-type: none"> a) Obtain a collateral history from the bed partner or parents, if possible and appropriate b) Assess the contribution of drugs (prescription, over-the-counter, recreational), caffeine, and alcohol 	<i>Clinical reasoning</i> <i>Clinical reasoning</i>	<i>History</i> <i>History</i> <i>Hypothesis generation</i>
3 In all patients with insomnia: <ul style="list-style-type: none"> a) Provide appropriate advice about sleep hygiene (e.g., limiting caffeine, naps, and screen time, following regular sleep schedule, limiting bedroom activities to sleep and sex) b) Offer other non-pharmacological options, such as cognitive behavioural therapy 	<i>Clinical reasoning</i> <i>Patient-centred Approach</i> <i>Clinical reasoning</i>	<i>Treatment</i> <i>Treatment</i>
4 When initiating sleep medications: <ul style="list-style-type: none"> a) Educate the patient about risks and discuss these medications' time-limited effects b) Use hypnotic medications judiciously (e.g., prescribe only when disordered sleep has a severe impact on function, and only with a clear indication) c) Negotiate a reduction and cessation plan with the patient 	<i>Clinical reasoning</i> <i>Communication</i> <i>Clinical reasoning</i> <i>Selectivity</i> <i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>Treatment</i> <i>Treatment</i>
5 When a patient with a long-term history of using sleep medication presents for renewal of their prescription reassess, educate, and discuss tapering and alternative therapies.	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Hypothesis generation</i> <i>Treatment</i>

Ischemic Heart Disease

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>1 Given a specific clinical scenario in the office or emergency setting, diagnose presentations of ischemic heart disease (IHD) that are:</p> <ul style="list-style-type: none"> • Classic • atypical (e.g., in women, those with diabetes, the young, those at no risk). 	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
<p>2 In a patient with modifiable risk factors for ischemic heart disease (e.g., smoking, diabetes control, obesity), develop a plan in collaboration with the patient to reduce her or his risk of developing the disease.</p>	<i>Clinical Reasoning</i>	<i>Treatment</i>
<p>3 In a patient presenting with symptoms suggestive of ischemic heart disease but in whom the diagnosis may not be obvious, do not eliminate the diagnosis solely because of tests with limited specificity and sensitivity (e.g., electrocardiography, exercise stress testing, normal enzyme results).</p>	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Investigation</i>
<p>4 In a patient with stable ischemic heart disease manage changes in symptoms with self-initiated adjustment of medication (e.g., nitroglycerin) and appropriate physician contact (e.g., office visits, phone calls, emergency department visits), depending on the nature and severity of symptoms.</p>	<i>Clinical Reasoning</i>	<i>Treatment</i>
<p>5 In the regular follow-up care of patients with established ischemic heart disease, specifically verify the following to detect complications and suboptimal control:</p> <ul style="list-style-type: none"> • symptom control. • medication adherence. • impact on daily activities. • lifestyle modification • clinical screening (i.e., symptoms and signs of complications) 	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Diagnosis</i>
<p>6 In a person with diagnosed acute coronary syndrome (e.g., cardiogenic shock, arrhythmia, pulmonary edema, acute myocardial infarction, unstable angina), manage the condition in an appropriate and timely manner.</p>	<i>Selectivity</i>	<i>Treatment</i>

Joint Disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with joint pain, distinguish benign from serious pathology (e.g., sarcoma, septic joint): a) By taking pertinent history b) By investigating in a timely and appropriate manner (e.g., aspirate, blood work, an X-ray examination).	Selectivity Clinical Reasoning Clinical Reasoning Selectivity	Hypothesis generation History Investigation Diagnosis
2 In a patient presenting with non-specific musculoskeletal pain, make a specific rheumatologic diagnosis when one is evident through history, physical examination, and investigations. (e.g., gout, fibromyalgia, monoarthropathy vs. polyarthropathy).	Clinical Reasoning	Diagnosis
3 In a patient presenting with a monoarthropathy, rule out infectious causes. (e.g., sexually transmitted diseases).	Selectivity Clinical Reasoning	Diagnosis Hypothesis generation
4 In patients presenting with musculoskeletal pain, include referred and visceral sources of pain in the differential diagnosis. (e.g., angina, slipped capital epiphysis presenting as knee pain, neuropathic pain).	Clinical Reasoning	Hypothesis generation
5 Clinically diagnose ligamentous injuries. Do NOT do an X-ray examination.	Clinical Reasoning Procedures Skills	Physical Diagnosis
6 In a patient presenting with joint pain, include systemic conditions in the differential diagnosis (e.g., Wegener's granulomatosis, lupus, ulcerative colitis).	Clinical Reasoning	Hypothesis generation
7 In patients with a diagnosed rheumatologic condition: a) Actively inquire about pre-existing co-morbid conditions that may modify the treatment plan. b) Choose the appropriate treatment plan (e.g., no nonsteroidal anti-inflammatory drugs in patients with renal failure or peptic ulcer disease).	Clinical Reasoning Clinical Reasoning	History Treatment
8 In assessing patients with a diagnosed rheumatologic condition, search for disease-related complications (e.g., iritis).	Clinical Reasoning	Hypothesis generation
9 In patients experiencing musculoskeletal pain: a) Actively inquire about the impact of the pain on daily life. b) Treat with appropriate doses of analgesics. c) Arrange for community resources and aids (e.g., splints, cane), if necessary.	Patient-centred Approach Clinical Reasoning Clinical Reasoning	History Treatment Treatment Referral
10 In patients with rheumatoid arthritis, start treatment with disease-modifying agents within an appropriate time interval.	Clinical Reasoning	Treatment

Lacerations

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When managing a laceration, identify those that are more complicated and may require special skills for repair (e.g., a second- versus third-degree perineal tear, lip or eyelid lacerations involving margins, arterial lacerations).	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Physical</i>
2 When managing a laceration, look for complications (e.g., flexor tendon lacerations, open fractures, bites to hands or face, neurovascular injury, foreign bodies) requiring more than simple suturing.	<i>Clinical Reasoning</i>	<i>Diagnosis Physical</i>
3 Given a deep or contaminated laceration, thoroughly clean with copious irrigation and debride when appropriate, before closing.	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 Identify wounds at high risk of infection (e.g., puncture wounds, some bites, some contaminated wounds), and do not close them.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Treatment</i>
5 When repairing lacerations in children, ensure appropriate analgesia (e.g., topical anesthesia) and/or sedation (e.g., procedural sedation) to avoid physical restraints.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 When repairing a laceration, allow for and take adequate time to use techniques that will achieve good cosmetic results (e.g., layer closure, revision if necessary, use of regional rather than local anesthesia).	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 In treating a patient with a laceration: a) Ask about immunization status for tetanus.	<i>Clinical Reasoning</i>	<i>History</i>
b) Immunize the patient appropriately.	<i>Clinical Reasoning</i>	<i>Treatment</i>

Learning (Patients/Self)

Patients

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 As part of the ongoing care of children, ask parents about their children's functioning in school to identify learning difficulties.	<i>Clinical Reasoning</i>	<i>History</i>
2 In children with school problems, take a thorough history to assist in making a specific diagnosis of the problem (e.g., mental health problem, learning disability, hearing).	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
3 When caring for a child with a learning disability, regularly assess the impact of the learning disability on the child and the family.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Hypothesis generation</i> <i>Follow-up</i>
4 When caring for a child with a learning disability, ensure the patient and family have access to available community resources to assist them.	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
5 To maximize the patient's understanding and management of their condition, a) Determine their willingness to receive information,	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Diagnosis</i> <i>History</i>
b) Match the complexity and amount of information provided with the patient's ability to understand.	<i>Communication Patient-centred Approach</i>	<i>Treatment</i>

Self Learning

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
6 Continuously assess your learning needs.	<i>Professionalism</i>	<i>NA</i>
7 Effectively address your learning needs.	<i>Professionalism</i> <i>Selectivity</i>	<i>NA</i>
8 Incorporate your new knowledge into your practice.	<i>Professionalism</i>	<i>NA</i>

Lifestyle

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In the ongoing care of patients, ask about behaviours that, if changed, can improve health (e.g., diet, exercise, alcohol use, substance use, safer sex, injury prevention (e.g., seatbelts and helmets)).	<i>Patient-centred Approach Communication</i>	<i>History</i>
2 Before making recommendations about lifestyle modification, explore a patient's readiness to change, as it may alter advice.	<i>Patient-centred Approach</i>	<i>Treatment History</i>
3 Explore a person's context (e.g., poverty) before making recommendations about lifestyle modification (e.g., healthy eating choices, exercise suggestions) so as to avoid making recommendations incompatible with the patient's context.	<i>Patient-centred Approach</i>	<i>Treatment History</i>
4 In the ongoing care of patients, periodically review their behaviours, recognizing that these may change.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Follow-up</i>
5 In the ongoing care of a patient, regularly reinforce advice about lifestyle modification, whether or not the patient has instituted a change in behaviour.	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>

Loss of Consciousness

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In an unconscious patient, assess ABC's and resuscitate as needed.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Treatment</i>
2 As part of the assessment of a patient who has lost consciousness, obtain focused history from the patient or witnesses that would include duration, trauma, preexisting conditions, drugs, toxins, medications and seizure activity.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
3 Examine unconscious patients for localizing and diagnostic signs (e.g., ketone smell, liver flap, focal neurologic signs).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Physical</i>
4 In patients with a loss of consciousness and a history of head trauma, rule out intracranial bleeding.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Investigation</i>
5 In patients with a loss of consciousness who are anticoagulated, rule out intracranial bleeding.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Investigation</i>
6 Assess and treat unconscious patients urgently for reversible conditions (e.g., shock, hypoxia, hypoglycemia, hyperglycemia, and narcotic overdose).	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Treatment</i>
7 When following up patients who have lost consciousness, assess and advise regarding return to work, sporting, driving and recreational activities to minimize the possibility of injury to self or others in the event of a recurrence.	<i>Clinical Reasoning Communication</i>	<i>Hypothesis generation Treatment</i>
8 In patients who have had a loss of consciousness without a clear diagnosis, pursue investigations (e.g., rule out transient arrhythmia, seizure).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Investigation</i>
9 When following up patients who have lost consciousness and where there is potential for recurrent episodes, discuss specific preventive and protective measures (e.g., position changes with orthostatic pressure changes).	<i>Clinical Reasoning</i>	<i>Treatment Hypothesis generation</i>
10 In patients with loss of consciousness following head trauma, treat and follow up according to current concussion guidelines.	<i>Clinical Reasoning Professionalism</i>	<i>Treatment Follow-up</i>
11 Advise authorities about appropriate patients with loss of consciousness (e.g., regarding driving status).	<i>Clinical Reasoning Professionalism</i>	<i>Treatment</i>

Loss of Weight

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Pursue an underlying cause in a patient with unexplained weight loss through history, physical examination (including weight) and appropriate investigations.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 Maintain an ongoing record of patients' weights so as to accurately determine when true weight loss has occurred.	<i>Professionalism</i>	<i>Physical</i>
3 In patients with persistent weight loss of undiagnosed cause, follow-up and reevaluate in a timely manner in order to decide whether anything needs to be done.	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Low-back Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with undefined acute low-back pain (LBP): a) Rule out serious causes (e.g., cauda equina syndrome, pyelonephritis, ruptured abdominal aortic aneurysm, cancer) through appropriate history and physical examination. b) Make a positive diagnosis of musculoskeletal pain (not a diagnosis of exclusion) through an appropriate history and physical examination.	Selectivity Clinical Reasoning	Hypothesis generation Diagnosis Diagnosis
2 In a patient with confirmed mechanical low back pain: a) Do not over-investigate in the acute phase. b) Advise the patient: <ul style="list-style-type: none"> that symptoms can evolve, and ensure adequate follow-up care that the prognosis is positive (i.e., the overwhelming majority of cases will get better) 	Clinical Reasoning Selectivity Clinical Reasoning	Investigation Treatment Treatment
3 In a patient with mechanical low back pain, whether it is acute or chronic, give appropriate analgesia and titrate it to the patient's pain.	Clinical Reasoning	Treatment
4 Advise the patient with mechanical low back pain to return if new or progressive neurologic symptoms develop.	Clinical Reasoning	Follow-up Treatment
5 In all patients with mechanical low back pain, discuss exercises and posture strategies to prevent recurrences.	Clinical Reasoning Patient-centred Approach	Treatment

Meningitis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In the patient with a non-specific febrile illness, look for meningitis, especially in patients at higher risk (e.g., immuno-compromised individuals, alcoholism, recent neurosurgery, head injury, recent abdominal surgery, neonates, aboriginal groups, students living in residence).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i>
2 When meningitis is suspected ensure a timely lumbar puncture.	<i>Selectivity</i>	<i>Investigation</i>
3 In the differentiation between viral and bacterial meningitis, adjust the interpretation of the data in light of recent antibiotic use.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
4 For suspected bacterial meningitis, initiate urgent empiric IV antibiotic therapy (i.e., even before investigations are complete).	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
5 Contact public health to ensure appropriate prophylaxis for family, friends and other contacts of each person with meningitis.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>

Menopause

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In any woman of menopausal age, screen for symptoms of menopause and (e.g., hot flashes, changes in libido, vaginal dryness, incontinence, and psychological changes).	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Hypothesis generation</i>
2 In a patient with typical symptoms suggestive of menopause, make the diagnosis without ordering any tests. (This diagnosis is clinical and tests are not required.)	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
3 In a patient with atypical symptoms of menopause (e.g., weight loss, blood in stools), rule out serious pathology through the history and selective use of tests, before diagnosing menopause.	<i>Selectivity</i>	<i>Hypothesis generation</i> <i>History</i>
4 In a patient who presents with symptoms of menopause but whose test results may not support the diagnosis, do not eliminate the possibility of menopause solely because of these results.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
5 When a patient has contraindications to hormone-replacement therapy (HRT), or chooses not to take HRT: Explore other therapeutic options and recommend some appropriate choices	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
6 In menopausal or perimenopausal women: a) Specifically inquire about the use of natural or herbal products.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>History</i>
b) Advise about potential effects and dangers (i.e., benefits and problems) of natural or herbal products and interactions.	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 In a menopausal or perimenopausal women, provide counselling about preventive health measures (e.g., osteoporosis testing, mammography).	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 Establish by history a patient's hormone-replacement therapy risk/benefit status.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>History</i>

Mental Competency

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with a diagnosis that may increase the likelihood of cognitive and/or functional impairment (e.g., dementia, stroke, severe mental illness, head injury):		
a) Assess the patient's level of competence in the context of the decision(s) that the patient needs to make, recognizing that higher-risk decisions require higher cognitive capacity	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>History</i> <i>Diagnosis</i>
b) Explain the purpose of the assessment and attempt to gain permission before you begin the assessment	<i>Communication</i> <i>Professionalism</i>	<i>History</i> <i>Investigation</i>
c) Include other professionals when appropriate	<i>Clinical reasoning</i> <i>Professionalism</i>	<i>Treatment</i> <i>Referral</i>
2 In an otherwise well patient with subtle changes in function (e.g., family concerns, medication errors, repetitive questions, decline in personal hygiene):		
a) Perform an appropriate assessment of cognitive and functional abilities	<i>Clinical reasoning</i> <i>Communication</i>	<i>Physical</i> <i>Investigation</i>
b) Refer for further assessment when necessary	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Referral</i>
3 When a patient is making high-stakes care decisions (e.g., surgery/no surgery, resuscitation status) think about the need to assess their decision-making ability.	<i>Clinical reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>
4 When capacity assessment is required, actively assess the patient's ability to understand, appreciate, reason, and express a choice.	<i>Clinical reasoning</i>	<i>Diagnosis</i> <i>Investigation</i>
5 When impaired decision-making ability is identified, attempt to establish severity, reversibility, and duration in order to plan treatment and regular reassessment.	<i>Clinical reasoning</i>	<i>History</i> <i>Diagnosis</i>
6 When a patient refuses to participate in capacity assessment:		
a) Document their refusal	<i>Communication</i>	<i>Treatment</i>
b) Continue to engage in the provision of safe care that is acceptable to the patient	<i>Professionalism</i>	<i>Treatment</i>
c) Revisit the assessment when indicated	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Follow-up</i>
d) Pursue the need for a substitute decision maker when necessary	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Follow-up</i> <i>Treatment</i>

7	When involuntary treatment is indicated:		
	a) Initiate the certification process	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
	b) Collaborate with colleagues/family regarding the procedures required	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
	c) Document and communicate according to legal requirements	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
	d) Help the patient and family understand why this is necessary	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
	e) Clarify your continuing role in the care of the patient	<i>Communication</i> <i>Professionalism</i>	<i>Follow-up</i>
8	When involuntary interventions that impact autonomy are required (e.g., loss of driver's licence) include management of the emotional impact on the patient and possible effects on the physician-patient relationship as parts of the treatment plan.	<i>Patient-centred Approach</i>	<i>Treatment</i>

Multiple Medical Problems

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients presenting with multiple medical concerns (e.g., complaints, problems, diagnoses), take an appropriate history to determine the primary reason for the consultation.	<i>Selectivity Clinical Reasoning</i>	<i>History</i>
2 In all patients presenting with multiple medical concerns, prioritize problems appropriately to develop an agenda that both you and the patient can agree upon (i.e., determine common ground).	<i>Patient-centred Approach</i>	<i>Treatment</i>
3 In a patient with multiple medical complaints (and/or visits), consider underlying depression, anxiety, or abuse (e.g., physical, medication, or drug abuse) as the cause of the symptoms, while continuing to search for other organic pathology.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
4 Given a patient with multiple defined medical conditions, periodically assess for secondary depression, as they are particularly at risk for it.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
5 Periodically re-address and re-evaluate the management of patients with multiple medical problems in order to: <ul style="list-style-type: none"> • simplify their management (pharmacologic and other) • limit polypharmacy • minimize possible drug interactions • update therapeutic choices (e.g., because of changing guidelines or the patient's situation) 	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
6 In patients with multiple medical problems and recurrent visits for unchanging symptoms, set limits for consultations when appropriate (e.g., limit the duration and frequency of visits).	<i>Patient-centred Approach Professionalism</i>	<i>Treatment Follow-up</i>

Neck Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with non-traumatic neck pain, use a focused history, physical examination and appropriate investigations to distinguish serious, non-musculoskeletal causes (e.g., lymphoma, carotid dissection), including those referred to the neck (e.g., myocardial infarction, pseudotumour cerebri) from other non-serious causes.	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
2 In patients with non-traumatic neck pain, distinguish by history and physical examination, those attributable to nerve or spinal cord compression from those due to other mechanical causes (e.g., muscular).	<i>Clinical Reasoning</i>	<i>History Physical</i>
3 Use a multi-modal (e.g., physiotherapy, chiropractic, acupuncture, massage) approach to treatment of patients with chronic neck pain (e.g., degenerative disc disease +/- soft neuro signs).	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 In patients with neck pain following injury, distinguish by history and physical examination, those requiring an X-ray to rule out a fracture from those who do not require an X-ray (e.g., current guideline/C-spine rules).	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Investigation</i>
5 When reviewing neck X-rays of patients with traumatic neck pain, be sure all vertebrae are visualized adequately.	<i>Clinical Reasoning</i>	<i>Diagnosis Investigation</i>

Newborn

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When examining a newborn, systematically look for subtle congenital anomalies (e.g., ear abnormalities, sacral dimple) as they may be associated with other anomalies and genetic syndromes.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Physical</i>
2 In a newborn, where a concern has been raised by a caregiver (parent, nurse), a) Think about sepsis, and b) Look for signs of sepsis, as the presentation can be subtle (i.e. not the same as in adults, non-specific, feeding difficulties, respiratory changes) c) Make a provisional diagnosis of sepsis.	<i>Clinical Reasoning</i> <i>Clinical Reasoning Selectivity</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Physical History</i> <i>Diagnosis</i>
3 Resuscitate newborns according to current guidelines.	<i>Clinical Reasoning Procedures Skills</i>	<i>Treatment</i>
4 Maintain neonatal resuscitation skills if appropriate for your practice.	<i>Professionalism</i>	<i>Treatment</i>
5 When a parent elects to bottle feed, support their decision in a non-judgemental manner.	<i>Professionalism Patient-centred Approach</i>	<i>Treatment</i>
6 In caring for a newborn ensure repeat evaluations for abnormalities that may become apparent over time (e.g., hips, heart, hearing).	<i>Clinical Reasoning</i>	<i>Follow-up Physical</i>
7 When discharging a newborn from hospital, a) Advise parent(s) of warning signs of serious or impending illness, and b) Develop a plan with them to access appropriate care should a concern arise.	<i>Clinical Reasoning Communication</i> <i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment Follow-up</i> <i>Follow-up</i>

Obesity

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients who appear to be obese, make the diagnosis of obesity using a clear definition (i.e., currently body mass index) and inform them of the diagnosis.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 In all obese patients, assess for treatable co-morbidities such as hypertension, diabetes, coronary artery disease, sleep apnea, and osteoarthritis, as these are more likely to be present.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 In patients diagnosed with obesity who have confirmed normal thyroid function, avoid repeated thyroid-stimulating hormone testing.	<i>Clinical Reasoning Selectivity</i>	<i>Investigation Treatment</i>
4 In obese patients, inquire about the effect of obesity on the patient's personal and social life to better understand its impact on the patient.	<i>Patient-centred Approach</i>	<i>History</i>
5 In a patient diagnosed with obesity, establish the patient's readiness to make changes necessary to lose weight, as advice will differ, and reassess this readiness periodically.	<i>Patient-centred Approach</i>	<i>History Follow-up</i>
6 Advise the obese patient seeking treatment that effective management will require appropriate diet, adequate exercise, and support (independent of any medical or surgical treatment), and facilitate the patient's access to these as needed and as possible.	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 As part of preventing childhood obesity, advise parents of healthy activity levels for their children.	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 In managing childhood obesity, challenge parents to make appropriate family-wide changes in diet and exercise, and to avoid counterproductive interventions (e.g., berating or singling out the obese child).	<i>Clinical Reasoning Communication</i>	<i>Treatment</i>

Osteoporosis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Assess osteoporosis risk of all adult patients as part of their periodic health examination.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 Use bone mineral density testing judiciously (e.g., don't test everybody, follow a guideline).	<i>Selectivity Professionalism</i>	<i>Investigation Follow-up</i>
3 Counsel all patients about primary prevention of osteoporosis (i.e., dietary calcium, physical activity, smoking cessation), especially those at higher risk (e.g., young female athletes, patients with eating disorders).	<i>Clinical Reasoning Communication</i>	<i>Treatment</i>
4 In menopausal or peri-menopausal women, provide advice about fracture prevention that includes improving their physical fitness, reducing alcohol, smoking cessation, risks of physical abuse, and environmental factors that may contribute to falls (e.g., don't stop at suggesting calcium and vitamin D).	<i>Clinical Reasoning Communication</i>	<i>Treatment Hypothesis generation</i>
5 In patients with osteoporosis, avoid prescribing medications that may increase the risk of falls.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
6 Provide advice and counseling about fracture prevention to older men, as they too are at risk for osteoporosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
7 Treat patients with established osteoporosis regardless of their gender (e.g., use bisphosphonates in men).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>

Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with acute pain provide analgesia while seeking a diagnosis.	Selectivity	Treatment
2 When assessing a patient with pain take a detailed history to recognize clinical patterns (diagnostic discerning characteristics) to inform diagnosis (e.g., neuropathic, vascular, muscular, visceral pain).	Clinical reasoning	History Hypothesis
3 In a patient presenting with pain without a clear diagnosis: a) Include life-threatening conditions in your differential diagnosis b) Investigate appropriately and in a timely manner	Selectivity Clinical reasoning Selectivity Clinical reasoning	Hypothesis Investigation
4 When there is a concern about drug-seeking behaviour in a patient with pain: a) Maintain your therapeutic relationship (e.g., be empathic, avoid stereotyping, manage frustration) b) Do not attribute the presentation to drug-seeking without first considering an appropriately broad differential diagnosis	Patient-centred Approach Professionalism Clinical reasoning Selectivity	Treatment Follow-up Hypothesis
5 When treating pain with narcotics: a) Dose appropriately considering narcotic naïveté and renal function b) Consider addiction risk c) Consider variable and potentially dangerous metabolic responses (e.g., codeine, especially in pregnant and breastfeeding women; sudden removal of a painful stimulus)	Clinical reasoning Clinical reasoning Clinical reasoning	Treatment Hypothesis Treatment Hypothesis Treatment
6 In a patient whose pain is not resolving or following the anticipated course, regularly re-evaluate (e.g., diagnosis, complications, medication choices, drug diversion).	Clinical reasoning	Hypothesis Follow-up
7 When prescribing medication for pain inform the patient not to use over-the-counter products that contain the same drug or drugs from the same class (e.g., acetaminophen, NSAIDs)	Clinical reasoning	Treatment
8 When treating a patient with pain appropriately use non-pharmacologic treatments and self-management strategies to control pain and optimize function.	Patient-centred Approach Clinical reasoning	Treatment
9 In a patient where acute pain has become chronic: a) Recognize the transition b) Readdress the treatment plan and your patient's expectations appropriately	Clinical reasoning Patient-centred Approach Communication	Diagnosis Treatment

Palliative Care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients with terminal illnesses (e.g., end-stage congestive heart failure or renal disease), use the principles of palliative care to address symptoms (i.e., do not limit the use of palliative care to cancer patients).	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
2 In patients requiring palliative care, provide support through self, other related disciplines, or community agencies, depending on patient needs (i.e., use a team approach when necessary).	<i>Patient-centred Approach</i>	<i>Treatment</i>
3 In patients approaching the end of life: a) Identify the individual issues important to the patient, including physical issues (e.g., dyspnea, pain, constipation, nausea), emotional issues, social issues (e.g., guardianship, wills, finances), and spiritual issues. b) Attempt to address the issues identified as important to the patient.	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>History</i>
	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
4 In patients with pain, manage it (e.g., adjust dosages, change analgesics) proactively through: <ul style="list-style-type: none"> • frequent reassessments • monitoring of drug side effects (e.g., nausea, constipation, cognitive impairment) 	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
5 In patients diagnosed with a terminal illness, identify and repeatedly clarify wishes about end-of-life issues (e.g., wishes for treatment of infections, intubation, dying at home)	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>

Parkinsonism

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with suspected Parkinson's disease, accurately distinguish idiopathic Parkinson's disease from atypical Parkinson's disease (e.g., disease at a young age, drug-related disease), as treatment differs.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 In the care of all patients with Parkinson's disease, involve other health care professionals to enhance the patient's functional status.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i> <i>Referral</i>
3 In an elderly patient with a deterioration in functional status, look for and recognize Parkinson's disease when it is present, as it is a potentially reversible contribution to the deterioration.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
4 In a patient with a tremor, do an appropriate physical examination (e.g., observation, use of techniques to enhance the tremor) to distinguish the resting tremor of parkinsonism from other (e.g., essential) tremors.	<i>Clinical Reasoning</i>	<i>Physical</i>
5 As part of the management of patients with Parkinson's disease, identify anticipated side effects of medications, especially those with which you are unfamiliar.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
6 As part of the ongoing follow-up care of patients with Parkinson's disease: <ul style="list-style-type: none"> • Assess functional status • Monitor them for medication side effects • Look for other problems (e.g., depression, dementia, falls, constipation), as they are more common 	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Follow-up</i>

Periodic Health Assessment/Screening

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Do a periodic health assessment in a proactive or opportunistic manner (i.e., address health maintenance even when patients present with unrelated concerns).	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 In any given patient, selectively adapt the periodic health examination to that patient's specific circumstances (i.e., adhere to inclusion and exclusion criteria of each manoeuvre/intervention, such as the criteria for mammography and prostate-specific antigen [PSA] testing).	<i>Selectivity</i> <i>Patient-centred Approach</i>	<i>Investigation</i> <i>Hypothesis generation</i>
3 In a patient requesting a test (e.g., PSA testing, mammography) that may or may not be recommended: a) Inform the patient about limitations of the screening test (i.e., sensitivity and specificity).	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Investigation</i>
b) Counsel the patient about the implications of proceeding with the test.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment Investigation</i>
4 Keep up to date with new recommendations for the periodic health examination, and critically evaluate their usefulness and application to your practice.	<i>Professionalism</i>	<i>Treatment</i> <i>Diagnosis</i>

Personality Disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When assessing a patient with personality traits or behaviours that impair interactions and/or function:		
a) Distinguish between isolated or intermittent manifestations and established, habitual patterns of behaviour	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>History</i>
b) Rule out pharmacologic or underlying medical causes (e.g., substance use, brain tumour)	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i>
c) Do not label the patient with a personality disorder prematurely or without clear justification (i.e., personality traits are not a disorder)	<i>Clinical reasoning</i>	<i>Diagnosis</i>
2 For any patient with a personality disorder or personality traits that impair interpersonal interaction:		
a) Adapt your communication style to optimize the development of a therapeutic relationship to provide effective care	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
b) Determine the impact of the patient's personality disorder on their ability to access health care	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
3 When providing care for a patient with a personality disorder reflect on, acknowledge, and manage your own emotional responses in order to provide empathetic and patient-centred care.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
4 When caring for a patient with a personality disorder or with difficult behaviours or requests:		
a) Address the behaviour in a direct but non-threatening manner	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
b) Co-create realistic goals and expectations with the patient	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
c) Establish and maintain clear boundaries and limits (e.g., appointment length, drug prescribing, accessibility) and communicate these to your team	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i> <i>Follow-up</i>
d) Continue the therapeutic relationship with the patient unless there is risk to you or others	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
5 In a patient already diagnosed with personality disorder look for medical and other psychiatric diagnoses when the patient presents for assessment of new or changed symptoms. (Patients with personality disorders develop medical and psychiatric conditions, too.)	<i>Clinical reasoning</i>	<i>Hypothesis generation</i>
6 When seeing a patient whom others have previously identified as having a personality disorder evaluate the patient yourself because the diagnosis may be wrong, and the label has significant repercussions.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Diagnosis</i>

Pneumonia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient who presents without the classic respiratory signs and symptoms (e.g., deterioration, delirium, abdominal pain), include pneumonia in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 In a patient with signs and symptoms of pneumonia, do not rule out the diagnosis on the basis of a normal chest X-ray film (e.g., consider dehydration, neutropenia, human immunodeficiency virus [HIV] infection).	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Hypothesis generation</i>
3 In a patient with a diagnosis of pneumonia, assess the risks for unusual pathogens (e.g., a history of tuberculosis, exposure to birds, travel, HIV infection, aspiration).	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
4 In patients with pre-existing medical problems (e.g., asthma, diabetes, congestive heart failure) and a new diagnosis of pneumonia: a) Treat both problems concurrently (e.g., with prednisone plus antibiotics). b) Adjust the treatment plan for pneumonia, taking into account the concomitant medical problems (e.g., be aware of any drug interactions, such as that between warfarin [Coumadin] and antibiotics).	<i>Clinical Reasoning Selectivity</i> <i>Clinical Reasoning Selectivity</i>	<i>Treatment</i> <i>Treatment Hypothesis generation</i>
5 Identify patients, through history-taking, physical examination, and testing, who are at high risk for a complicated course of pneumonia and would benefit from hospitalization, even though clinically they may appear stable.	<i>Selectivity</i>	<i>History Diagnosis</i>
6 In the patient with pneumonia and early signs of respiratory distress, assess, and reassess periodically, the need for respiratory support (bilevel positive airway pressure, continuous positive airway pressure, intubation) (i.e., look for the need before decompensation occurs).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
7 For a patient with a confirmed diagnosis of pneumonia, make rational antibiotic choices (e.g., outpatient + healthy = first-line antibiotics; avoid the routine use of “big guns”).	<i>Clinical Reasoning Professionalism</i>	<i>Treatment</i>

8 In a patient who is receiving treatment for pneumonia and is not responding:	Clinical Reasoning	Hypothesis generation Diagnosis
a) Revise the diagnosis (e.g., identify other or contributing causes, such as cancer, chronic obstructive pulmonary disease, or bronchospasm), consider atypical pathogens (e.g., <i>Pneumocystis carinii</i> , TB, and diagnose complications (e.g., empyema, pneumothorax).	Clinical Reasoning	Treatment Diagnosis
b) Modify the therapy appropriately (e.g., change antibiotics).		
9 Identify patients (e.g., the elderly, nursing home residents, debilitated patients) who would benefit from immunization or other treatments (e.g., flu vaccine, Pneumovax, ribavarine) to reduce the incidence of pneumonia.	Clinical Reasoning Selectivity	Treatment
10 In patients with a diagnosis of pneumonia, ensure appropriate follow-up care (e.g., patient education, repeat chest X-ray examination, instructions to return if the condition worsens).	Clinical Reasoning	Follow-up
11 In patients with a confirmed diagnosis of pneumonia, arrange contact tracing when appropriate (e.g., in those with TB, nursing home residents, those with legionnaires' disease).	Clinical Reasoning	Follow-up Referral

Poisoning

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 As part of well-child care, discuss preventing and treating poisoning with parents (e.g., “child-proofing”, poison control number).	Communication Clinical Reasoning	Treatment
2 In intentional poisonings (overdose) think about multi-toxin ingestion.	Clinical Reasoning	Hypothesis generation
3 When assessing a patient with a potentially toxic ingestion, take a careful history about the timing and nature of the ingestion.	Clinical Reasoning	History
4 When assessing a patient with a potential poisoning, do a focused physical examination to look for the signs of toxidromes.	Clinical Reasoning	Physical
5 When assessing a patient exposed (contact or ingestion) to a substance, clarify the consequences of the exposure (e.g., don’t assume it is non-toxic, call poison control).	Clinical Reasoning	Hypothesis generation Treatment
6 When managing a toxic ingestion, utilize poison control protocols that are current.	Clinical Reasoning Professionalism	Treatment
7 When managing a patient with a poisoning, a) Assess ABC’s,	Clinical Reasoning	Hypothesis generation Diagnosis
b) Manage ABC’s,	Clinical Reasoning	Treatment
c) Regularly reassess the patient’s ABC’s (i.e., do not focus on antidotes and decontamination while ignoring the effect of the poisoning on the patient).	Clinical Reasoning	Hypothesis generation Treatment

Pregnancy

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient who is considering pregnancy: a) Identify risk factors for complications. b) Recommend appropriate changes (e.g., folic acid intake, smoking cessation, medication changes).	Clinical Reasoning Patient-centred Approach Clinical Reasoning Patient-centred Approach	Hypothesis generation Diagnosis Treatment
2 In a female or male patient who is sexually active, who is considering sexual activity, or who has the potential to conceive or engender a pregnancy, use available encounters to educate about fertility.	Communication Patient-centred Approach	Treatment
3 In a patient with suspected or confirmed pregnancy, establish the desirability of the pregnancy.	Clinical Reasoning Patient-centred Approach	History Treatment
4 In a patient presenting with a confirmed pregnancy for the first encounter: a) Assess maternal risk factors (medical and social). b) Establish accurate dates. c) Advise the patient about ongoing care.	Clinical Reasoning Patient-centred Approach Clinical Reasoning Clinical Reasoning	Hypothesis generation History Diagnosis Treatment
5 In pregnant patients: a) Identify those at high risk (e.g., teens, domestic violence victims, single parents, drug abusers, impoverished women). b) Refer these high-risk patients to appropriate resources throughout the antepartum and postpartum periods.	Clinical Reasoning Selectivity Clinical Reasoning	Hypothesis generation History Treatment Referral
6 In at-risk pregnant patients (e.g., women with human immunodeficiency virus infection, intravenous drug users, and diabetic or epileptic women), modify antenatal care appropriately.	Selectivity Clinical Reasoning	Treatment
7 In a pregnant patient presenting with features of an antenatal complication (e.g., premature rupture of membranes, hypertension, bleeding): a) Establish the diagnosis. b) Manage the complication appropriately.	Clinical Reasoning Selectivity Clinical Reasoning Selectivity	Hypothesis generation Diagnosis Treatment
8 In a patient presenting with dystocia (prolonged dilatation, failure of descent): a) Diagnose the problem. b) Intervene appropriately.	Clinical Reasoning Selectivity Clinical Reasoning Selectivity	Hypothesis generation Diagnosis Treatment

9 In a patient with clinical evidence of complications in labour (e.g., abruption, uterine rupture, shoulder dystocia, non-reassuring fetal monitoring):	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Hypothesis generation</i> <i>Diagnosis</i>
a) Diagnose the complication.	
b) Manage the complication appropriately.	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Treatment</i>
10 In the patient presenting with clinical evidence of a postpartum complication (e.g., delayed or immediate bleeding, infection):	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Hypothesis generation</i> <i>Diagnosis</i>
a) Diagnose the problem (e.g., unrecognized retained placenta, endometritis, cervical laceration).	
b) Manage the problem appropriately.	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Treatment</i>
11 In pregnant or postpartum patients, identify postpartum depression by screening for risk factors, monitoring patients at risk, and distinguishing postpartum depression from the “blues.”	<i>Selectivity</i> <i>Hypothesis generation</i> <i>Clinical Reasoning</i> <i>Diagnosis</i>
12 In a breast-feeding woman, screen for and characterize dysfunctional breast-feeding (e.g., poor latch, poor production, poor letdown).	<i>Clinical Reasoning</i> <i>Hypothesis generation</i> <i>Patient-centred Approach</i> <i>History</i>

Prostate

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Appropriately identify patients requiring prostate cancer screening.	<i>Selectivity</i>	<i>Diagnosis History</i>
2 In a patient suitable for prostate cancer screening, use and interpret tests (e.g., prostate-specific antigen testing, digital rectal examination [DRE], ultrasonography) in an individualized/sequential manner to identify potential cases.	<i>Selectivity Patient-centred Approach</i>	<i>Investigation Diagnosis</i>
3 In patients with prostate cancer, actively search out the psychological impact of the diagnosis and treatment modality.	<i>Patient-centred Approach Communication</i>	<i>History</i>
4 In patients with prostate cancer, considering a specific treatment option (e.g., surgery, radiotherapy, chemotherapy, hormonal treatment, no treatment): a) Advise about the risks and benefits of treatment. b) Monitor patients for complications following treatment.	<i>Clinical Reasoning Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment Hypothesis generation Follow-up</i>
5 In patients with prostate cancer, actively ask about symptoms of local recurrence or distant spread.	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
6 Given a suspicion of benign prostatic hypertrophy, diagnose it using appropriate history, physical examination, and investigations.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
7 In patients presenting with specific or non-specific urinary symptoms: a) Identify the possibility of prostatitis. b) Interpret investigations (e.g., urinalysis, urine culture-and-sensitivity testing, Digital Rectal Exam, swab testing, reverse transcription-polymerase chain reaction assay) appropriately.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i> <i>Diagnosis Investigation</i>

Rape/Sexual Assault

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Provide comprehensive care to all patients who have been sexually assaulted, regardless of their decision to proceed with evidence collection or not.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
2 Apply the same principles of managing sexual assault in the acute setting to other ambulatory settings (i.e. medical assessment, pregnancy prevention, STI screening/treatment/prophylaxis, counselling).	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 Limit documentation in sexual assault patients to observations and other necessary medical information (i.e., avoid recording hearsay information).	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>History</i>
4 In addition to other post-exposure prophylactic measures taken, assess the need for human immunodeficiency virus and hepatitis B prophylaxis in patients who have been sexually assaulted.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
5 Offer counselling to all patients affected by sexual assault, whether they are victims, family members, friends, or partners; do not discount the impact of sexual assault on all of these people.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 Revisit the need for counselling in patients affected by sexual assault.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
7 Enquire about undisclosed sexual assault when seeing patients who have symptoms such as depression, anxiety, and somatization.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>

Rash

Key Feature	Skill	Phase
1 In a patient with a new rash: a) Take a focused history and do an appropriate skin examination b) If the diagnosis remains unclear obtain a more detailed history and examination, including the entire mucocutaneous system and other body systems as indicated	Clinical reasoning Selectivity Clinical reasoning Selectivity	History Physical History Physical
2 When assessing a patient with a rash look for and recognize common patterns to aid diagnosis.	Clinical reasoning	Diagnosis
3 Use appropriate terminology with respect to lesion type, shape, arrangement, and distribution to facilitate communication and documentation	Communication	Physical Follow-up
4 In an unwell patient presenting with a rash: a) Identify potential life-threatening systemic conditions (e.g., meningococcal septicemia, necrotizing fasciitis, toxic shock, Stevens-Johnson syndrome) b) Initiate treatment and/or urgent/emergent referral	Clinical reasoning Selectivity Selectivity	Hypothesis Diagnosis Treatment Referral
5 In a patient with a persisting undiagnosed rash: a) Consider a systemic disorder (e.g., systemic lupus erythematosus, diabetes, celiac) b) Investigate appropriately (e.g., scraping, culture, biopsy, lab work) c) Pursue further investigations and/or refer as indicated regardless of negative results	Clinical reasoning Clinical reasoning Procedure skills Clinical reasoning	Hypothesis Investigation Hypothesis Follow-up
6 In all patients with a persistent or recurrent rash explore the functional and emotional aspects of that disorder, recognizing that what looks like a minor condition may have a profound impact.	Patient-centred Approach	History Follow-up
7 7 In a patient with a persistent or recurrent rash explore issues of: <ul style="list-style-type: none"> • Exposure to skin irritants or allergens • Adherence to the treatment plan • Use of confounding medications and treatments (e.g., topical anesthetics, topical steroids, home remedies) 	Clinical reasoning Patient-centred Approach	Hypothesis
8 In a patient with an infectious rash: a) Manage contagion risk b) Ensure that public health bodies are informed when indicated	Clinical reasoning Selectivity Clinical reasoning Professionalism	Treatment Follow-up

Red Eye

Key Feature	Skill	Phase
1 In addressing eye complaints, always assess visual acuity using history, physical examination, or the Snellen chart, as appropriate.	Clinical Reasoning	History Physical
2 In a patient with a red eye, distinguish between serious causes (e.g., keratitis, glaucoma, perforation, temporal arteritis) and non-serious causes (i.e., do not assume all red eyes are caused by conjunctivitis): a) Take an appropriate history (e.g., photophobia, changes in vision, history of trauma). b) Do a focused physical examination (e.g., pupil size, and visual acuity, slit lamp, fluorescein). c) Do appropriate investigations (e.g., erythrocyte sedimentation rate measurement, tonometry). d) Refer the patient appropriately (if unsure of the diagnosis or if further work-up is needed).	Clinical Reasoning Clinical Reasoning Clinical Reasoning Clinical Reasoning	History Physical Investigation Referral
3 In patients presenting with an ocular foreign body sensation, correctly diagnose an intraocular foreign body by clarifying the mechanism of injury (e.g., high speed, metal on metal, no glasses) and investigating (e.g., with computed tomography, X-ray examination) when necessary.	Clinical Reasoning	Hypothesis generation Diagnosis
4 In patients presenting with an ocular foreign body sensation, evert the eyelids to rule out the presence of a conjunctival foreign body.	Clinical Reasoning Procedures Skills	Hypothesis generation Physical
5 In neonates with conjunctivitis (not just blocked lacrimal glands or “gunky” eyes), look for a systemic cause and treat it appropriately (i.e., with antibiotics).	Clinical Reasoning	Hypothesis generation Treatment
6 In patients with conjunctivitis, distinguish by history and physical examination between allergic and infectious causes (viral or bacterial).	Clinical Reasoning	Diagnosis History
7 In patients who have bacterial conjunctivitis and use contact lenses, provide treatment with antibiotics that cover for <i>Pseudomonas</i> .	Clinical Reasoning	Treatment
8 Use steroid treatment only when indicated (e.g., to treat iritis; avoid with keratitis and conjunctivitis).	Clinical Reasoning	Treatment
9 In patients with iritis, consider and look for underlying systemic causes (e.g., Crohn’s disease, lupus, ankylosing spondylitis).	Clinical Reasoning	Hypothesis generation

Renal Failure

	<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1	In patients with chronic renal failure ensure they are aware of their diagnosis and its implications.	Communication Patient-centred Approach	Treatment
2	In any patient mitigate the risks of precipitating renal failure when investigation and treatment combinations are likely to be harmful (e.g., metformin and contrast dye, bowel preparation).	Clinical reasoning	Hypothesis Treatment
3	When prescribing drugs to a patient in renal failure: a) Determine drug safety (e.g., interactions, dose adjustments, metabolic considerations) b) Adjust doses when appropriate (e.g., ACE inhibitors, angiotensin II receptor blockers, metformin, allopurinol, antibiotics, low molecular weight heparin, direct oral anticoagulants) c) Monitor the impact of the drug on the renal function more frequently	Clinical reasoning Clinical reasoning Clinical reasoning Selectivity	Treatment Treatment Follow-up
4	Advise patients with existing moderate or severe renal failure to pay close attention to hydration (e.g., when travelling, elderly patients in hot weather, when ill) to avoid exacerbating their condition.	Clinical reasoning	Treatment
5	Advise patients with existing renal failure to avoid certain over-the-counter treatments (e.g., NSAIDs, herbals, supplements) as they may worsen their condition.	Clinical reasoning	Treatment
6	In patients with moderate or severe renal failure provide anticipatory guidance that if they become ill and cannot maintain fluid intake they should: <ul style="list-style-type: none"> • Stop certain medications promptly (e.g., ACE inhibitors, diuretics) • Seek prompt reassessment 	Clinical reasoning Selectivity	Treatment
7	In a patient with an exacerbation of their renal failure (acute on chronic renal failure): a) Correct factors (e.g., hydration, pneumonia, congestive heart failure, urinary retention) b) Stop drugs that might be aggravating the situation (e.g., ACE inhibitors, metformin) c) Determine the appropriateness of restarting medications, once renal function has stabilized	Clinical reasoning Clinical reasoning Selectivity Clinical reasoning Selectivity	Treatment Treatment Treatment
8	Monitor patients with renal failure periodically, as some patients will worsen over time.	Clinical reasoning	Follow-up
9	For patients with renal failure determine, based on patient factors and local resources, if and when consultation is required (e.g., progressive renal failure, bone disease, refractory anemia, mild renal failure in a young person).	Clinical reasoning Selectivity	Treatment Follow-up
10	Ensure those involved in consultant care of patients with renal failure are aware of other important health considerations that may affect decision making around treatment (e.g., patient preferences, frailty, malignancy, consideration of dialysis in patients with cognitive impairment).	Communication	Follow-up Referral

Schizophrenia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In adolescents and young adults presenting with problem behaviours: a) Consider schizophrenia in the differential diagnosis	<i>Clinical reasoning</i>	<i>Hypothesis generation Diagnosis</i>
b) Reassess the diagnosis as the situation evolves	<i>Clinical reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 In apparently stable patients with schizophrenia (e.g., those who are not floridly psychotic) assess periodically in a structured fashion (ideally seeking collateral information from family members and other caregivers): • Positive and negative symptoms • Performance of activities of daily living and their level of social functioning • Ideation of harm to themselves or others, including the risk for violence • Medication compliance and side effects • Substance use • Capacity to accept or refuse treatment	<i>Clinical reasoning</i>	<i>History</i>
3 When caring for patients with psychosis clearly communicate limits of confidentiality to the patient and the family	<i>Professionalism Communication</i>	<i>Treatment</i>
4 In all patients presenting with psychotic symptoms inquire about substance use and abuse.	<i>Clinical reasoning</i>	<i>History</i>
5 In patients with schizophrenia ensure early treatment and follow-up, including referral and collaborative care, because this may improve prognosis.	<i>Clinical reasoning Communication</i>	<i>Treatment Referral</i>
6 In decompensating patients with schizophrenia determine if substance use is a contributor, whether there are medication compliance and side-effect problems, and if psychosocial supports have changed.	<i>Clinical reasoning</i>	<i>Hypothesis generation Diagnosis</i>
7 In a decompensating patient with schizophrenia, a) Determine whether they meet the criteria for involuntary treatment b) Help the patient understand why this is necessary c) Clarify your continuing role in care	<i>Clinical Reasoning Professionalism Communication Patient Centred Communication</i>	<i>Diagnosis Treatment Referral Follow-up</i>
8 Diagnose and manage serious complications/side effects of antipsychotic medications (e.g., neuroleptic malignant syndrome, tardive dyskinesia, cardiometabolic risks).	<i>Clinical reasoning</i>	<i>Treatment Diagnosis</i>
9 Include psychosocial supports (e.g., social determinants of health, family support, disability issues, vocational rehabilitation) as part of the treatment plan for patients with schizophrenia.	<i>Patient-centred Approach Selectivity</i>	<i>Treatment Referral</i>

Seizures

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient having a seizure: a) Ensure proper airway control (e.g., oropharyngeal airway or nasal trumpet, lateral decubitus to prevent aspiration).	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Use drugs (e.g., benzodiazepines, phenytoin) promptly to stop the seizure, even before the etiology is confirmed.	<i>Clinical Reasoning</i>	<i>Treatment</i>
c) Rule out reversible metabolic causes in a timely fashion (e.g., hypoglycemia, hypoxia, heat stroke, electrolytes abnormalities).	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Hypothesis generation</i>
2 In a patient presenting with an ill-defined episode (e.g., fits, spells, turns), take a history to distinguish a seizure from other events.	<i>Clinical Reasoning</i>	<i>History</i>
3 In a patient presenting with a seizure, take an appropriate history to direct the investigation (e.g., do not overinvestigate; a stable known disorder may require only a drug-level measurement, while new or changing seizures may require an extensive work-up).	<i>Clinical Reasoning</i>	<i>History</i>
4 In all patients presenting with a seizure, examine carefully for focal neurologic findings.	<i>Clinical Reasoning</i>	<i>Physical</i>
5 In a patient with a previously known seizure disorder, who presents with a seizure or a change in the pattern of seizures: a) Assess by history the factors that may affect the primary seizure disorder (e.g., medication compliance, alcohol use, lifestyle, recent changes in medications [not just antiepileptic medications], other illnesses).	<i>Clinical Reasoning</i>	<i>History</i>
b) Include other causes of seizure in the differential diagnosis. (Not all seizures are caused by epilepsy.)	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
6 In the ongoing care of a patient with a stable seizure disorder: a) Regularly inquire about compliance (with medication and lifestyle measures), side effects of anticonvulsant medication, and the impact of the disorder and its treatment on the patient's life (e.g., on driving, when seizures occur at work or with friends).	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment History</i>
b) Monitor for complications of the anticonvulsant medication (e.g., hematologic complications, osteoporosis).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
c) Modify management of other health issues taking into account the anticonvulsant medication (e.g., in prescribing antibiotics, pregnancy).	<i>Clinical Reasoning</i>	<i>Treatment</i>

Sex

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Ask about sexual health and function, in a sensitive manner, when appropriate, e.g.: <ul style="list-style-type: none"> • In conditions with higher risk for sexual dysfunction (e.g., post-MI, diabetes, use of certain medications) • Throughout life cycle transitions (e.g., adolescence, pregnancy, menopause, andropause) • Not assuming sexual inactivity within specific populations (e.g., people with disabilities, seniors, singles) 	<i>Clinical reasoning</i>	<i>History</i>
2 Educate patients about sexual health, consent, and safety, especially patients at risk (e.g., for stigmatization, exploitation), using plain language appropriate to the age, developmental stage, and culture of the patient.	<i>Clinical reasoning</i> <i>Communication</i>	<i>Treatment</i>
3 With a patient (especially adolescents or those in vulnerable situations) presenting with a concern about sex or sexuality explicitly discuss confidentiality.	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
4 In a patient presenting with sexual dysfunction, perform a thorough assessment (including specific systems; mental health; alcohol and substance use; relationship factors and impacts; medication; and sexual history, including positive and negative experiences) to make an accurate diagnosis.	<i>Clinical reasoning</i>	<i>History</i> <i>Hypothesis generation</i>
5 When caring for a patient with gender or sexuality-related concerns: <ol style="list-style-type: none"> a) Take opportunities to destigmatize gender and sexuality-related concerns (e.g., using the person's preferred pronoun, using terms such as partner instead of boyfriend) b) Identify and recognize your own biases, manage them, and ensure the patient receives appropriate care c) Differentiate between sexual orientation, gender identity, and sexual function d) Refer the patient to appropriate specialty care when indicated e) Inform the patient about available community resources 	<i>Communication</i> <i>Patient-centred Approach</i> <i>Professionalism</i> <i>Clinical reasoning</i> <i>Selectivity</i> <i>Clinical reasoning</i>	<i>History</i> <i>Treatment</i> <i>History</i> <i>Treatment</i> <i>History</i> <i>Referral</i> <i>Treatment</i>
6 When performing a physical examination that triggers an unexpected response: <ol style="list-style-type: none"> a) Acknowledge the response b) Stop the examination c) Discuss the response in a sensitive manner, respecting the dignity of the patient d) Decide on next steps together with the patient 	<i>Professionalism</i> <i>Communication</i> <i>Professionalism</i> <i>Communication</i> <i>Professionalism</i> <i>Patient-centred Approach</i> <i>Communication</i>	<i>Physical</i> <i>Treatment</i> <i>Physical</i> <i>Treatment</i> <i>Treatment</i> <i>Treatment</i>

Sexually Transmitted Infections

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient who is sexually active or considering sexual activity, take advantage of opportunities to advise her or him about prevention, screening, and complications of sexually transmitted diseases (STIs).	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
2 In a patient with symptoms that are atypical or non-specific for STIs (e.g., dysuria, recurrent vaginal infections): a) Consider STIs in the differential diagnosis. b) Investigate appropriately.	<i>Selectivity</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Investigation</i>
3 In high-risk patients who are asymptomatic for STIs, screen and advise them about preventive measures.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Investigation</i>
4 In high-risk patients who are symptomatic for STIs, provide treatment before confirmation by laboratory results.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
5 In a patient requesting STI testing: a) Identify the reason(s) for requesting testing. b) Assess the patient's risk. c) Provide counselling appropriate to the risk (i.e., human immunodeficiency virus [HIV] infection risk, non-HIV risk).	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>Treatment</i> <i>History</i> <i>Diagnosis</i> <i>Diagnosis</i> <i>Treatment</i>
6 In a patient with a confirmed STI, initiate: • treatment of partner(s). • contact tracing through a public health or community agency.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
7 Use appropriate techniques for collecting specimens.	<i>Procedures</i> <i>Skills</i> <i>Clinical Reasoning</i>	<i>Investigation</i> <i>Physical</i>
8 Given a clinical scenario that is strongly suspicious for an STI and a negative test result, do not exclude the diagnosis of an STI (i.e., because of sensitivity and specificity problems or other test limitations).	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Investigation</i>

Shortness of Breath

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with a new presentation of shortness of breath take a sufficient history to avoid inappropriately or prematurely limiting the diagnosis to respiratory and cardiac causes (i.e., consider causes such as hematologic, environmental, psychogenic, deconditioning, gastrointestinal).	<i>Clinical reasoning</i>	<i>Hypothesis</i> <i>History</i>
2 Regardless of where you assess the patient who presents with shortness of breath (e.g., office, home visit) consider life-threatening conditions (e.g., pulmonary embolus, foreign body aspiration in a child, anaphylaxis, myocardial infarction).	<i>Selectivity</i>	<i>Hypothesis</i>
3 When a patient with a diagnosed cause of dyspnea presents with worsening symptoms or treatment failure: <ul style="list-style-type: none"> a) Ask about other factors that might have exacerbated their symptoms (e.g., new pets, environmental factors, medication technique/adherence, dietary changes) b) Re-evaluate your primary diagnosis (i.e., the original diagnosis may have been incorrect) c) Consider co-existing diagnoses (e.g., a patient with asthma who has pneumonia) 	<i>Clinical reasoning</i>	<i>Hypothesis</i> <i>History</i>
4 In an anxious patient with shortness of breath don't assume anxiety is the cause of their symptoms.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Hypothesis</i>

Skin Disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In dealing with a persistent skin problem that is not responding to treatment as expected: a) Reconsider the diagnosis (e.g., “eczema” may really be a fungal infection). b) Investigate or modify treatment (e.g., for acne).	Clinical Reasoning Clinical Reasoning	Hypothesis generation Diagnosis Treatment Investigation
2 In a patient presenting with a skin lesion, distinguish benign from serious pathology (e.g., melanoma, pemphigus, cutaneous T-cell lymphoma) by physical examination and appropriate investigations (e.g., biopsy or excision).	Selectivity Clinical Reasoning	Physical Investigation
3 In a patient presenting with a cutaneous manifestation of a systemic disease or condition (e.g., Wegener’s granulomatosis, lupus, a drug reaction), consider the diagnosis of systemic disease and confirm it through history, physical examination, and appropriate investigations.	Clinical Reasoning	Hypothesis generation Diagnosis
4 When prompted by a patient with a concern about a localized skin lesion or when screening for mucocutaneous lesions, inspect all areas of the skin (e.g., nails, scalp, oral cavity, perineum, soles of the feet, back of the neck).	Clinical Reasoning	Physical
5 Diagnose and promptly treat suspected life-threatening dermatologic emergencies (e.g., Stevens-Johnson syndrome, invasive cellulitis, chemical or non-chemical burns).	Selectivity	Diagnosis Hypothesis generation
6 In high-risk patients (diabetics, bed or chair bound, peripheral vascular disease): a) Examine the skin even when no specific skin complaint is present. b) Treat apparently minor skin lesions aggressively.	Clinical Reasoning Clinical Reasoning	Selectivity Physical Treatment
7 In a patient being treated for a new or persistent skin condition (e.g., acne, psoriasis), determine the impact on the patient’s personal and social life.	Patient-centred Approach	Treatment History

Smoking Cessation

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, regularly evaluate and document smoking status, recognizing that people may stop or start at any time.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Follow-up</i>
2 In smokers: a) Discuss the benefits of quitting or reducing smoking.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
b) Regularly assess interest in quitting or reducing smoking.	<i>Clinical Reasoning</i>	<i>History Follow-up</i>
3 In smokers motivated to quit, advise the use of a multi-strategy approach to smoking cessation.	<i>Clinical Reasoning Communication</i>	<i>Treatment Follow-up</i>

Somatization

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with recurrent unexplained or confusing symptoms: a) Do not attribute symptoms to somatization unless an adequate workup rules out any medical or psychiatric condition (e.g., depression) b) Reassess the symptoms periodically as they may evolve into diagnosable medical conditions/mental health diagnoses or remain unexplained	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
2 When a patient presents with symptoms that may be somatoform (e.g., caused by emotional distress) clearly distinguish between the stressed individual with somatoform traits and somatic symptom disorder by using established diagnostic criteria.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i>
3 In patients with a previously diagnosed somatic symptom disorder do not assume that somatization is the cause of new or ongoing symptoms.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i>
4 In patients who somatize acknowledge the illness experience and strive to find common ground with them concerning their diagnosis and management, including investigations.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Diagnosis</i> <i>Treatment</i>
5 When a patient presents frequently with medically inconsistent or confusing symptoms that are not worrisome: a) Order investigations judiciously b) Educate the patient about the connection between physical symptoms and psychological distress	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Investigation</i>
6 In a patient with existing mental health conditions do not dismiss new physical symptoms as somatization without appropriate assessment.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>Treatment</i> <i>Follow-up</i>
7 When caring for a patient with somatization identify and manage your own emotional responses.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
8 When somatic symptom disorder has been established as the most likely diagnosis recommend and discuss evidence-informed psychotherapy and refer when appropriate, ensuring appropriate ongoing care and follow-up.	<i>Patient-centred Approach</i> <i>Clinical reasoning</i>	<i>Treatment</i> <i>Referral</i>
9 In patients who have somatic symptoms inquire about the use of and suggest therapies that may provide symptomatic relief and/or help them cope with their symptoms.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Treatment</i>

Stress

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with a symptom that could be attributed to stress (e.g., headache, fatigue, pain) consider and ask about stress as a cause or contributing factor.	Clinical Reasoning Communication	Hypothesis generation History
2 In a patient in whom stress is identified, assess the impact of the stress on their function (i.e., coping vs. not coping, stress vs. distress).	Patient-centred Approach	History Diagnosis
3 In patients not coping with stress, look for and diagnose, if present, mental illness (e.g., depression, anxiety disorder).	Clinical Reasoning	Hypothesis generation Diagnosis
4 In patients not coping with the stress in their lives, a) Clarify and acknowledge the factors contributing to the stress, b) Explore their resources and possible solutions for improving the situation.	Patient-centred Approach Clinical Reasoning Patient-centred Approach	History History Treatment
5 In patients experiencing stress, look for inappropriate coping mechanisms (e.g., drugs, alcohol, eating, violence).	Clinical Reasoning Communication	Hypothesis generation History

Stroke

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients presenting with symptoms and/or signs suggestive of stroke, include other diagnoses in the differential diagnosis (e.g., transient ischemic attack [TIA], brain tumour, hypoglycemia, subdural hematoma, subarachnoid bleed).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 In a patient presenting with a stroke, differentiate, if possible, hemorrhagic from embolic/thrombotic stroke (e.g., through the history, physical examination, and ancillary testing, such as scanning and electrocardiography), as treatment differs.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
3 Assess patients presenting with neurologic deficits in a timely fashion, to determine their eligibility for thrombolysis.	<i>Selectivity</i>	<i>Treatment</i>
4 In a patient diagnosed with stroke, involve other professionals as needed (e.g., a physical therapist, an occupational therapist, social service personnel, a psychiatrist, a neurologist) to ensure the best outcome for the patient.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Referral</i>
5 When caring for a stroke patient with severe/serious deficits, involve the patient and her or his family in decisions about intervention (e.g., resuscitation, use of a feeding tube, treatment of pneumonia).	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
6 In patients who have suffered stroke, diagnose “silent” cognitive deficits (not associated with sensory or motor symptoms or signs, such as inattention and impulsivity) when they are present.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
7 Provide realistic prognostic advice about their disabilities to stroke patients and their families.	<i>Patient-centred Approach</i>	<i>Treatment</i>
8 In stroke patients with disabilities, evaluate the resources and supports needed to improve function (e.g., a cane, a walker, home care).	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
9 In the continuing care of stroke patients with deficits (e.g., dysphagia, being bedridden), include the prevention of certain complications (e.g., aspiration pneumonia, decubitus ulcer) in the treatment plan, as they are more common.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Hypothesis generation</i>
10 In patients at risk of stroke, treat modifiable risk factors (e.g., atrial fibrillation, diabetes, hyperlipidemia, and hypertension).	<i>Clinical Reasoning</i>	<i>Treatment</i>
11 In all patients with a history of TIA or completed stroke, and in asymptomatic patients at high risk for stroke, offer antithrombotic treatment (e.g., acetylsalicylic acid, clopidogrel) to appropriate patients to lower stroke risk.	<i>Clinical Reasoning</i>	<i>Treatment</i>

Substance use and addiction

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, and especially in high-risk groups (e.g., those with mental health issues, chronic disability), opportunistically ask about substance use (tobacco, alcohol, other substances).	<i>Patient-centred Approach</i> <i>Selectivity</i>	<i>History</i> <i>Hypothesis generation</i>
2 For a patient using alcohol or substances (including those who use them only occasionally): a) Discuss the possible impact of their use on themselves and others (e.g., risk to children, sexual indiscretion) b) Discuss harm-reduction strategies in detail (e.g., needle exchange, not drinking and driving, immunizations)	<i>Patient-centred Approach</i> <i>Professionalism</i> <i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Treatment</i>
3 For any patient presenting with a functional decline, confusion, or delirium, assess for alcohol/substance use and withdrawal, even when other causes may seem more apparent.	<i>Clinical reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
4 Discuss substance use with adolescents and their caregivers when warning signs are present (e.g., school failure, behaviour change).	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>Treatment</i>
5 Consider and look for substance use as a possible factor in problems not responding to appropriate intervention (e.g., alcohol use in patients with hypertriglyceridemia, inhalational drug use in asthmatic patients).	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>Treatment</i>
6 For a patient with a medical problem being treated with opioids, stimulants, sedatives, or hypnotics: a) Episodically reassess their clinical problem to affirm the ongoing need for the medication b) Discuss tapering and cessation planning when appropriate c) Discuss safety and security of medication (e.g. storing, risk to children, diversion, misuse)	<i>Clinical reasoning</i> <i>Selectivity</i> <i>Clinical reasoning</i> <i>Patient-centred Approach</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Follow-up</i> <i>Treatment</i> <i>Follow-up</i> <i>Treatment</i>
7 For a patient requesting or requiring a new prescription for opioids, stimulants, or tranquillizers: a) Assess alcohol and substance use b) Explain clearly the benefits and risks, and do not prescribe before the risks of misuse have been assessed and mitigated	<i>Clinical reasoning</i> <i>Clinical reasoning</i> <i>Professionalism</i>	<i>History</i> <i>Hypothesis generation</i> <i>Treatment</i>
8 In patients who use substances or those with a substance use disorder, regularly determine their readiness to change their patterns of use.	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Diagnosis</i> <i>Follow-up</i>

<p>9 For a patient with an alcohol or substance use disorder, assess their level of motivation and engage them in the development of an individualized plan for withdrawal and ongoing treatment that involves:</p> <ul style="list-style-type: none"> • Appropriate use of pharmacotherapy (e.g., methadone, acamprosate) • Use of community resources and other health professionals • Appropriate follow-up with you 	<p><i>Patient-centred Approach</i> <i>Clinical reasoning</i></p>	<p><i>Treatment</i></p>
<p>10 In patients with a substance use disorder take advantage of opportunities to screen for comorbidities (e.g., poverty, crime, sexually transmitted infections, mental health issues) and long-term complications (e.g., cirrhosis).</p>	<p><i>Clinical reasoning</i> <i>Patient-centred Approach</i></p>	<p><i>History</i> <i>Physical</i></p>
<p>11 Offer support to patients and family members affected by substance use disorder. (The user may not be your patient.)</p>	<p><i>Patient-centred Approach</i></p>	<p><i>Treatment</i></p>

Suicide

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Actively inquire about suicidal and homicidal ideation (e.g., ideas, thoughts, a specific plan), particularly when caring for patients with chronic illness, mental illness, or substance use problems; recent loss or emotional distress; impulsivity; or repeated suicidal ideation or attempts.	<i>Clinical reasoning</i> <i>Selectivity</i>	<i>History</i>
2 Given a suicidal patient, assess the degree of risk (e.g., thoughts, specific plans, access to means, impulsivity) to determine an appropriate intervention and follow-up plan.	<i>Clinical reasoning</i>	<i>Diagnosis</i>
3 In patients who present with self-injury (e.g., cutting):		
a) Assess the risk of suicide, but do not assume that this is a suicidal gesture (not all people who cut are suicidal, but some are)	<i>Clinical reasoning</i>	<i>History</i>
b) Explore the underlying emotional distress	<i>Patient-centred Approach</i>	<i>History</i>
c) Discuss alternative adaptive coping strategies	<i>Clinical reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
4 In patients at low risk of suicide whom you are managing in the community:		
a) Provide specific instructions for follow-up	<i>Communication</i>	<i>Follow-up</i>
b) Develop an appropriate contingency plan with the patient should their suicidal ideation progress/worsen	<i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
5 When assessing and managing a patient at risk of harm to themselves or others that has been reported by proxy, balance the patient's and the informant's rights to confidentiality with the risk of harm to the patient, the informant, or others.	<i>Clinical reasoning</i> <i>Professionalism</i>	<i>Diagnosis</i> <i>Treatment</i>
6 In suicidal patients presenting at the emergency department with a suspected drug overdose always screen for acetylsalicylic acid and acetaminophen overdoses as these are common, dangerous, and frequently overlooked.	<i>Clinical reasoning</i>	<i>Hypothesis generation</i> <i>Investigation</i>
7 In trauma patients consider attempted suicide as the precipitating cause.	<i>Clinical reasoning</i>	<i>History</i> <i>Hypothesis generation</i>

Thyroid

Key Feature	Skill	Phase
<p>1 Limit testing for thyroid disease to appropriate patients, namely those with a significant pre-test probability of abnormal results, such as:</p> <ul style="list-style-type: none"> • those with classic signs or symptoms of thyroid disease • those whose symptoms or signs are not classic, but who are at a higher risk for disease (e.g., the elderly, postpartum women, those with a history of atrial fibrillation, those with other endocrine disorders) 	Clinical Reasoning Selectivity	Investigation
<p>2 In patients with established thyroid disease, do not check thyroid-stimulating hormone levels too often, but rather test at the appropriate times, such as:</p> <ul style="list-style-type: none"> • after changing medical doses • when following patients with mild disease before initiating treatment • periodically in stable patients receiving treatment 	Clinical Reasoning Selectivity	Investigation
<p>3 When examining the thyroid gland, use proper technique (i.e., from behind the patient, ask the patient to swallow), especially to find nodules (which may require further investigation).</p>	Procedures Skills	Physical
<p>Note: The investigation of thyroid nodules is not covered here.</p>		

Trauma

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Assess and stabilize trauma patients with an organized approach, anticipating complications in a timely fashion, using the primary and secondary surveys.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Physical</i>
2 Suspect, identify, and immediately begin treating life-threatening complications (e.g., tension pneumothorax, tamponade).	<i>Selectivity</i>	<i>Treatment</i> <i>Diagnosis</i>
3 When faced with several trauma patients, triage according to resources and treatment priorities.	<i>Selectivity</i>	<i>Treatment</i>
4 In trauma patients, secure the airway appropriately (e.g., assume cervical spine injury, use conscious sedation, recognize a difficult airway, plan for back-up methods/cricothyrotomy).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i> <i>Hypothesis generation</i>
5 In a patient with signs and symptoms of shock: a) Recognize the shock.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
b) Define the severity and type (neurogenic, hypovolemic, septic).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Physical</i> <i>Diagnosis</i>
c) Treat the shock.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
6 In trauma patients, rule out hypothermia on arrival and subsequently (as it may develop during treatment).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Physical</i>
7 Suspect certain medical problems (e.g., seizure, drug intoxication, hypoglycemia, attempted suicide) as the precipitant of the trauma.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
8 Do not move potentially unstable patients from treatment areas for investigations (e.g., computed tomography, X-ray examination).	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Investigation</i>
9 Determine when patient transfer is necessary (e.g., central nervous system bleeds, when no specialty support is available).	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
10 Transfer patients in an appropriate manner (i.e., stabilize them before transfer and choose the method, such as ambulance or flight).	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
11 Find opportunities to offer advice to prevent or minimize trauma (e.g., do not drive drunk, use seatbelts and helmets).	<i>Clinical Reasoning</i>	<i>Treatment</i>
12 In children with traumatic injury, rule out abuse. (Carefully assess the reported mechanism of injury to ensure it corresponds with the actual injury.)	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Hypothesis generation</i>

Travel Medicine

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Make sure travelers get up to date, timely, itinerary-specific advice from a reliable source (e.g., travel clinic, travel website).	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
2 When seeing patients planning travel, discuss the common, non-infectious perils of travel (e.g., accidents, safer sex, alcohol, safe travel for women).	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
3 In patients presenting with symptoms of infection without an obvious cause, especially those with a fever, enquire about recent travel history to identify potential sources (especially, but not exclusively, malaria).	<i>Patient-centred Approach Communication</i>	<i>Hypothesis generation Follow-up</i>
4 Provide prevention and treatment advice and prescribe medications for common conditions associated with travel (e.g., traveler's diarrhea, altitude sickness).	<i>Patient-centred Approach Clinical Reasoning</i>	<i>Treatment Referral</i>
5 Ensure patients understand how to manage their chronic disease while traveling (e.g., diabetes, asthma, international normalized ratios [INRs]).	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 Use patient visits for travel advice as an opportunity to update routine vaccinations.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment Hypothesis generation</i>
7 Advise patients to check insurance coverage issues especially in regard to recent changes in chronic disease and any recent treatment changes.	<i>Professionalism</i>	<i>Treatment Hypothesis generation</i>
8 Advise patients traveling with medications to have an adequate supply, documentation of need for use, and to transport them securely (e.g., carry-on bag).	<i>Clinical Reasoning</i>	<i>Treatment Hypothesis generation</i>

Upper Respiratory Tract Infection

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given an appropriate history and/or physical examination: a) Differentiate life-threatening conditions (epiglottitis, retropharyngeal abscess) from benign conditions. b) Manage the condition appropriately.	Selectivity Clinical Reasoning	Diagnosis Treatment
2 Make the diagnosis of bacterial sinusitis by taking an adequate history and performing an appropriate physical examination, and prescribe appropriate antibiotics for the appropriate duration of therapy.	Clinical Reasoning	History Treatment
3 In a patient presenting with upper respiratory symptoms: a) Differentiate viral from bacterial infection (through history and physical examination). b) Diagnose a viral upper respiratory tract infection (URTI) (through the history and a physical examination). c) Manage the condition appropriately (e.g., do not give antibiotics without a clear indication for their use).	Clinical Reasoning Clinical Reasoning Clinical Reasoning Communication	History Diagnosis Diagnosis Treatment
4 Given a history compatible with otitis media, differentiate it from otitis externa and mastoiditis, according to the characteristic physical findings.	Clinical Reasoning	Diagnosis Physical
5 In high-risk patients (e.g., those who have human immunodeficiency virus infection, chronic obstructive pulmonary disease, or cancer) with upper respiratory infections: Look for complications more aggressively, and follow up more closely.	Clinical Reasoning	Hypothesis generation Follow-up
6 In a presentation of pharyngitis, look for mononucleosis.	Clinical Reasoning	Hypothesis generation Physical
7 In high-risk groups: a) Take preventive measures (e.g., use flu and pneumococcal vaccines). b) Treat early to decrease individual and population impact (e.g., with oseltamivir phosphate [Tamiflu], amantadine).	Selectivity Patient-centred Approach Clinical Reasoning Professionalism	Treatment Treatment

Urinary Tract Infection

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Take an appropriate history and do the required testing to exclude serious complications of urinary tract infection (UTI) (e.g., sepsis, pyelonephritis, impacted infected stones).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Investigation</i>
2 Appropriately investigate all boys with urinary tract infections, and young girls with recurrences (e.g., ultrasound).	<i>Clinical Reasoning</i>	<i>Investigation</i>
3 In diagnosing urinary tract infections, search for and/or recognize high-risk factors on history (e.g., pregnancy; immune compromise, neonate, a young male, or an elderly male with prostatic hypertrophy).	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
4 In a patient with a diagnosed urinary tract infection, modify the choice and duration of treatment according to risk factors (e.g., pregnancy, immunocompromise, male extremes of age); and treat before confirmation of culture results in some cases (e.g., pregnancy, sepsis, pyelonephritis).	<i>Selectivity</i>	<i>Treatment</i>
5 Given a non-specific history (e.g., abdominal pain, fever, delirium) in elderly or very young patients, suspect the diagnosis and do an appropriate work-up.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Investigation</i>
6 In a patient with dysuria, exclude other causes (e.g., sexually transmitted diseases, vaginitis, stones, interstitial cystitis, prostatitis) through an appropriate history, physical examination, and investigation before diagnosing a urinary tract infection.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>

Vaginal Bleeding

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In any woman with vaginal bleeding, rule out pregnancy.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 In pregnant patients with vaginal bleeding a) Consider worrisome causes (e.g., ectopic pregnancy, abruption, abortion), and confirm or exclude the diagnosis through appropriate interpretation of test results. b) Do not forget blood typing and screening, and offer rH immunoglobulin treatment, if appropriate. c) Diagnose (and treat) hemodynamic instability.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Selectivity Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i> <i>Treatment Hypothesis generation</i> <i>Diagnosis Treatment</i>
3 In a non-pregnant patient with vaginal bleeding: a) Do an appropriate work-up and testing to diagnose worrisome causes (e.g., cancer), using an age-appropriate approach. b) Diagnose (and treat) hemodynamic instability. c) Manage hemodynamically stable but significant vaginal bleeding (e.g., with medical versus surgical treatment).	<i>Clinical Reasoning</i> <i>Clinical Reasoning Selectivity</i> <i>Clinical Reasoning</i>	<i>Investigation Diagnosis</i> <i>Diagnosis Treatment</i> <i>Treatment</i>
4 In a post-menopausal woman with vaginal bleeding, investigate any new or changed vaginal bleeding in a timely manner (e.g., with endometrial biopsy testing, ultrasonography, computed tomography, a Pap test, and with a pelvic examination).	<i>Clinical Reasoning</i>	<i>Investigation</i>

Vaginitis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with recurrent symptoms of vaginal discharge and/or perineal itching, have a broad differential diagnosis (e.g., lichen sclerosus et atrophicus, vulvar cancer, contact dermatitis, colovaginal fistula), take a detailed history, and perform a careful physical examination to ensure appropriate investigation or treatment. (Do not assume that the symptoms indicate just a yeast infection.)	<i>Clinical Reasoning</i>	<i>Hypothesis generation Physical</i>
2 In patients with recurrent vaginal discharge, no worrisome features on history or physical examination, and negative tests, make a positive diagnosis of physiologic discharge and communicate it to the patient to avoid recurrent consultation, inappropriate treatment, and investigation in the future.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
3 When bacterial vaginosis and candidal infections are identified through routine vaginal swab or Pap testing, ask about symptoms and provide treatment only when it is appropriate.	<i>Clinical Reasoning Selectivity</i>	<i>History Treatment</i>
4 In a child with a vaginal discharge, rule out sexually transmitted infections and foreign bodies. (Do not assume that the child has a yeast infection.)	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
5 In a child with a candidal infection, look for underlying illness (e.g., immunocompromise, diabetes).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>

Violent/Aggressive Patient

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In certain patient populations (e.g., intoxicated patients, psychiatric patients, patients with a history of violent behaviour):		
a) Anticipate possible violent or aggressive behaviour.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
b) Recognize warning signs of violent/aggressive behaviour.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
c) Have a plan of action before assessing the patient (e.g., stay near the door, be accompanied by security or other personnel, prepare physical and/or chemical restraints if necessary).	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 In all violent or aggressive patients, including those who are intoxicated, rule out underlying medical or psychiatric conditions (e.g., hypoxemia, neurologic disorder, schizophrenia) in a timely fashion (i.e., don't wait for them to sober up, and realize that their calming down with or without sedation does not necessarily mean they are better).	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i>
3 In a violent or aggressive patient, ensure the safety (including appropriate restraints) of the patient and staff before assessing the patient.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
4 In managing your practice environment (e.g., office, emergency department), draw up a plan to deal with patients who are verbally or physically aggressive, and ensure your staff is aware of this plan and able to apply it.	<i>Professionalism</i>	<i>Treatment</i>

Well-baby Care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Measure and chart growth parameters, including head circumference, at each assessment; examine appropriate systems at appropriate ages, with the use of an evidence-based pediatric flow sheet such as the Rourke Baby Record.	<i>Clinical Reasoning</i> <i>Procedures Skills</i>	<i>Physical</i>
2 Modify the routine immunization schedule in those patients who require it (e.g., those who are immunocompromised, those who have allergies).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Anticipate and advise on breast-feeding issues (e.g., weaning, returning to work, sleep patterns) beyond the newborn period to promote breast-feeding for as long as it is desired.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Hypothesis generation</i> <i>Treatment</i>
4 At each assessment, provide parents with anticipatory advice on pertinent issues (e.g., feeding patterns, development, immunization, parenting tips, antipyretic dosing, safety issues).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Ask about family adjustment to the child (e.g., sibling interaction, changing roles of both parents, involvement of extended family).	<i>Patient-centred Approach</i>	<i>History</i>
6 With parents reluctant to vaccinate their children, address the following issues so that they can make an informed decision: <ul style="list-style-type: none"> • their understanding of vaccinations. • the consequences of not vaccinating (e.g., congenital rubella, death). • the safety of unvaccinated children (e.g., no Third World travel). 	<i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>Treatment</i> <i>History</i>
7 When recent innovations (e.g., new vaccines) and recommendations (e.g., infant feeding, circumcision) have conflicting, or lack defined, guidelines, discuss this information with parents in an unbiased way to help them arrive at an informed decision.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
8 Even when children are growing and developing appropriately, evaluate their nutritional intake (e.g., type, quality, and quantity of foods) to prevent future problems (e.g., anemia, tooth decay), especially in at-risk populations (e.g., the socioeconomically disadvantaged, those with voluntarily restricted diets, those with cultural variations)	<i>Clinical Reasoning</i>	<i>History</i> <i>Treatment</i>

Appendices

Priority Topics and Key Features for Rural and Remote Family Medicine

Priority Topics and Key Features for Intrapartum and Perinatal Care

Priority Topics and Key Features for Mental Health (other than those that overlap with the existing priority topics for family medicine)

2010 List of Core Procedures in Family Medicine

Priority Topics and Key Features for Rural and Remote Family Medicine²⁰

Priority Topics

1. [Trauma](#)
2. [Patient transfer](#)
3. [Septicemia](#)
4. [Pediatric emergencies](#)
5. [Acute cardiac presentations](#)
6. [Psychiatric emergencies](#)
7. [Diabetic emergencies](#)
8. [Active airway management](#)
9. [Urgent respiratory presentation](#)
10. [Fracture and dislocation management](#)
11. [Intrapartum care](#)
12. [Altered level of consciousness](#)
13. [Procedural sedation](#)
14. [Chronic pain](#)
15. [Indigenous health](#)
16. [Clinical courage](#)
17. [Adapting to rural life](#)
18. [Cultural safety and sensitivity](#)

²⁰ Suggested citation: Blau E, Cambell G, Chase C, Dhillon P, Miller K, Geller B, et al. *Priority Topics and Key Features for the Assessment of Competence in Rural and Remote Family Medicine*. Mississauga, ON: College of Family Physicians of Canada; 2018

Trauma

Key Feature	Skill	Phase
1 When a patient presents with trauma: a) Assess and stabilize life-threatening conditions using a standardized approach before addressing non-life-threatening distracting injuries. b) Reassess thoroughly while considering mechanisms of injury, possible underlying causes (e.g., intoxication, seizure, physical abuse), and patient as a whole. c) Have a high index of suspicion for significant injuries, and differentiate between multi-organ and single-system trauma	Clinical Reasoning Selectivity Clinical Reasoning Selectivity Clinical Reasoning Selectivity	Diagnosis Treatment Diagnosis Follow-up Hypothesis generation Diagnosis
2 When a need for transfer is suspected, initiate transfer process early. (see also Patient transfer)	Selectivity Communication	Treatment Referral
3 In a complex trauma situation (e.g., multi-patient), assume the leadership role by: <ul style="list-style-type: none"> • Communicating clearly • Multitasking and triaging appropriately • Assigning roles to your team members • Mobilizing your community's resources (e.g., off-service doctors, firefighters, police, clergy) early 	Professionalism	Treatment
4 When treating patients with trauma, a) Reassess regularly for change in patient condition b) Maintain communication with the team, as well as the family, and inform them of any changes	Clinical Reasoning Communication	Hypothesis generation Follow-up Treatment Follow-up

See also: [Trauma](#) and [Loss of Consciousness](#)

Patient transfer

Key Feature	Skill	Phase
<p>1 With any patient potentially requiring transfer, consider the following factors:</p> <ul style="list-style-type: none"> ✦ Patient stability ✦ Own and resources' limitations ✦ Weather conditions and geographic factors ✦ Prolonged transfer delays ✦ Socio-cultural aspects, and patient's and family wishes 	Clinical Reasoning Selectivity	Hypothesis generation Treatment
<p>2 For all patients, assess and recognize those needing immediate transfer and do not delay the transfer for paperwork or further investigation unless it will change immediate management.</p>	Clinical Reasoning Selectivity	Treatment Referral
<p>3 When a transfer has been decided:</p> <p>a) Stabilize the patient and continue to reassess the conditions for transfer (e.g., weather) and patient's status</p> <p>b) Initiate communication with the receiving team, clearly and assertively articulating needs and reasons for transfer</p> <p>c) Assess for the best method(s) of transportation based on the patient's condition, and weather and geographic factors</p> <p>d) Anticipate possible transfer complications (e.g., barometric trauma, pressure sores) and prepare the patient accordingly (e.g., ensure IV lines and airway are secured, ensure adequate warming)</p> <p>e) Identify the need for accompanying health professionals and consider the implications on the remaining health team and community</p> <p>f) Ensure ongoing communication with the family, the receiving hospital, and the team</p> <p>g) Ensure adequate documentation</p>	Clinical Reasoning Selectivity Clinical Reasoning Communication Selectivity Clinical Reasoning Procedure Professionalism Selectivity Communication Communication	Treatment Follow-up Treatment Referral Hypothesis generation Referral Hypothesis generation Treatment Hypothesis generation Treatment Referral Follow-up Referral Follow-up
<p>4 1. During the transfer:</p> <p>a) Ensure regular reassessment of the patient's status, including body temperature and pressure points</p> <p>b) Maintain communication with the receiving hospital</p> <p>a) Remain engaged and intervene as necessary until the safe handover to the receiving physician</p>	Clinical Reasoning Communication Communication Professionalism	Treatment Follow-up Referral Follow-up Referral Follow-up

See also: Trauma

Septicemia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a patient presenting with an infection: a) Recognize early symptoms and signs of sepsis, based on currently accepted guidelines	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
b) Be alert to presentations that can be subtle and atypical (e.g., in newborns, children, the elderly)	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation</i>
c) Consider patients at risk (e.g., patients on biologic agents, patients with addiction)	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 For a patient presenting with signs and symptoms of sepsis: a) Manage with antibiotics immediately; do not delay treatment if there is difficulty in obtaining investigations (e.g., collecting culture, imaging)	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
b) Be aware of the local antibiotic resistance patterns and institute therapy as indicated	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Treatment</i>
c) Consider antiviral and/or antifungal therapy	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
3 Monitor septic patients closely and manage without delay as these patients decompensate quickly: <ul style="list-style-type: none"> • Recognize septic shock • Recognize the need for vasopressors • Proactively consider patient transfer, based on local treatment norms and capacity 	<i>Selectivity</i>	<i>Treatment Follow-up</i>
4 When treating a septic patient, contact Public Health where applicable to ensure contacts are treated appropriately.	<i>Communication Professionalism</i>	<i>Treatment Follow-up</i>

See also: [Infection](#)

Pediatric emergencies

Key Feature	Skill	Phase
1 When a child presents in distress:		
a) Anticipate rapid deterioration regardless of the setting, and identify life-threatening situations; do not underestimate the seriousness of symptoms if the child presents at the office and not the emergency department	Clinical Reasoning Selectivity	History Hypothesis generation
b) Do not delay treatment and/or transfer when appropriate	Clinical Reasoning Selectivity	Hypothesis generation Treatment
c) Mobilize appropriate resources	Clinical Reasoning Communication	Treatment
2 When assessing a child in distress:		
a) Check vital signs and measure height, weight, and glucose	Clinical Reasoning Procedures Skills	Physical
b) Perform a comprehensive physical examination, recognizing that the history might be incomplete and considering that certain illnesses may present differently in children	Clinical Reasoning Procedures Skills	Physical
c) Consider child abuse as an etiology and take appropriate action	Clinical Reasoning	Hypothesis generation
3 When developing a management plan for a child in distress:		
a) Prepare available pediatric equipment and supplies (e.g., intraosseous access, Broselow-pediatric emergency tape)	Procedures Skills	Hypothesis generation Treatment
b) Base dosage on estimated weight, not age	Clinical Reasoning Procedures Skills	Treatment
4 When managing a child in distress:		
a) Be prepared for rapid decompensation	Clinical Reasoning Selectivity	Hypothesis generation Treatment
b) Monitor constantly following a systematic approach, and be prepared to resuscitate	Clinical Reasoning Selectivity	Treatment Follow-up
5 After managing a pediatric emergency and especially after a negative outcome:		
a) Recognize the emotional impact on family, staff, the community, and yourself,	Patient-centred Approach Professionalism	Follow-up
b) Debrief and address consequences appropriately	Communication Professionalism	Follow-up

See also: [Advanced Cardiac Life Support](#) and [Trauma](#)

Acute cardiac presentations

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a patient with an acute cardiac presentation:		
a) Recognize the potentially unstable patient and the need for immediate intervention, consultation, and/ or transfer	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
b) Maintain a high index of suspicion and recognize variable presentations according to gender, age, and lifestyle	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
2 For a patient presenting with symptoms indicative of a myocardial infarction:		
a) Order and interpret the ECG and available laboratory results in a timely fashion	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Investigation</i>
b) Initiate treatment based on patient presentation and ECG findings, in an environment where cardiac serology is not available	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
c) Identify patients requiring thrombolysis, considering absolute and relative contraindications, and manage any complications that arise	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
d) Assess the need for telephone consultation versus immediate or delayed transfer	<i>Clinical Reasoning Selectivity</i>	<i>Treatment Referral</i>

See also: [Ischemic Heart Disease](#) and [Chest Pain](#)

Psychiatric emergencies

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When developing a differential diagnosis for a patient presenting in a psychiatric crisis, consider cultural differences and potential underlying causes.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
2 For a patient with a diagnosed psychiatric crisis, identify safe disposition, taking into account: <ul style="list-style-type: none"> • Cultural and geographic setting • Local resources • Caregiver fatigue 	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 When considering admitting or transferring a patient in psychiatric crisis: <p>a) Follow the provincial or territorial Mental Health Act, and be aware of the limitations of your local facility to admit and care for psychiatric emergencies</p> <p>b) Ensure safety for the patient, family, and staff</p> <p>c) Advocate strongly for the patient's admission to the appropriate level of care</p>	<i>Clinical Reasoning Professionalism</i>	<i>Treatment</i>
	<i>Professionalism</i>	<i>Treatment</i>
	<i>Communication Professionalism</i>	<i>Treatment Referral</i>
4 When transferring a patient in psychiatric crisis, consider their need for sedation.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
5 If faced with a co-worker, friend, or family member in a psychiatric crisis, recognize the possibility of your own discomfort, consult early, and hand over care as soon as possible.	<i>Professionalism</i>	<i>Treatment Referral</i>

See also: [Schizophrenia](#), [Depression](#) and [Suicide](#)

Diabetic emergencies

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a patient presenting with symptoms indicative of a blood sugar related emergency:		
a) Consider and identify hypo- and hyperglycemia even with atypical presentations (e.g., young patients with other symptoms, patients on newer classes of diabetic medications)	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
b) Assess for underlying causes (e.g., infection, acute coronary syndrome)	<i>Clinical Reasoning</i>	<i>History Diagnosis</i>
c) Evaluate the need for transfer	<i>Clinical Reasoning Selectivity</i>	<i>Treatment Referral</i>
2 For a patient presenting with a hyperglycemic emergency;		
a) Differentiate diabetic ketoacidosis (DKA) from hyperosmolar hyperglycemic state (HHS)	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Assess the severity of the metabolic derangement	<i>Clinical Reasoning</i>	<i>Investigation Diagnosis</i>
3 For a patient with diagnosed DKA or HHS, follow a systematic approach to management, including using:		
• Point of care tools	<i>Clinical Reasoning</i>	<i>Treatment</i>
• Laboratory resources		
• Local, tertiary, and online resources		
• Currently accepted guidelines		
4 Following an acute diabetic emergency, educate the patient and the family about the prevention (including use of local resources) and early recognition of future, similar episodes.	<i>Clinical Reasoning Communication</i>	<i>Treatment Follow-up</i>

See also: [Diabetes](#)

Active airway management

Key Feature	Skill	Phase
1 When considering active airway management, use a systematic approach to assessment and identify: <ul style="list-style-type: none"> • Urgency of the situation • Indications and contraindications to the interventions being considered • Available resources (human, equipment, and medications) Possibility of prolonged ventilation support requirements	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
2 Before securing the airway: <ol style="list-style-type: none"> a) Prepare all necessary equipment b) Always anticipate a difficult airway and be prepared to use alternative strategies (e.g., laryngeal mask, surgical airways) 	<i>Procedures Skills</i>	<i>Hypothesis generation Treatment</i>
3 After securing the airway: <ol style="list-style-type: none"> a) Clinically confirm airway placement b) Continue to reassess and be prepared for rapid changes in the patient's status c) Ensure eye care, naso-gastric drainage, and urinary catheter d) Consider capnography and chest X-ray to confirm placement 	<i>Clinical Reasoning</i>	<i>Physical</i>
4 When transferring an intubated patient: <ol style="list-style-type: none"> a) Confirm the correct placement of endotracheal tube at each patient transfer point b) Consider specialized transfer requirements (e.g., saline in the cuff, pressure point padding) 	<i>Clinical Reasoning</i>	<i>Physical Follow-up</i>
	<i>Clinical Reasoning</i>	<i>Treatment</i>

See also: [Advanced Cardiac Life Support](#) and [Trauma](#)

Urgent respiratory presentations

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a patient presents in respiratory distress:		
a) Manage the distress immediately	<i>Selectivity</i>	<i>Treatment</i>
b) Develop a differential diagnosis relying on clinical skills, augmenting with imaging when available	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
c) Differentiate between upper and lower airway etiologies	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 When managing a patient in respiratory distress:		
a) Consider early active airway management (e.g., inhalation injury, pulmonary contusion), based on the patient's condition and the available resources	<i>Clinical Reasoning Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
b) Re-evaluate regularly as symptoms evolve and as more information becomes available, bearing in mind that decompensation can occur quickly	<i>Clinical Reasoning</i>	<i>Follow-up</i>
c) Consider transfer before the patient's needs exceed local capabilities	<i>Clinical Reasoning Professionalism</i>	<i>Referral</i>
3 For a patient with upper airway compromise, act promptly to relieve the obstruction (e.g., peritonsillar abscess, epistaxis, foreign object, epiglottitis).	<i>Procedures Skills Selectivity</i>	<i>Treatment</i>

See also: [Active airway management](#), [Upper Respiratory Tract Infection](#), [Pneumonia](#) and [Chest Pain](#)

Fracture and dislocation management

Key Feature	Skill	Phase
1 For a patient presenting with a fracture or dislocation, assess for vascular compromise and neurologic deficit and document.	Clinical Reasoning Communication	Physical Diagnosis
2 For a patient with vascular compromise, promptly reduce the fracture and/or dislocation without waiting for imaging.	Procedures Skills Selectivity	Treatment
3 For a patient presenting with a suspected fracture: a) Splint and immobilize as appropriate and consider analgesia b) Order appropriate imaging (e.g., specific view, joint above and below), based on the urgency of the situation and the available resources c) Maintain a high index of suspicion for an undisplaced fracture even if the initial X-ray is negative	Clinical Reasoning Procedures Skills Clinical Reasoning Selectivity Clinical Reasoning	Treatment Investigation Hypothesis generation Investigation
4 For patients with significant fractures, anticipate complications (e.g., thrombo-embolism, compartment syndrome, occult hemorrhage) and manage accordingly.	Clinical Reasoning Selectivity	Hypothesis generation Treatment
5 Consider appropriate consultation for certain cases, such as: <ul style="list-style-type: none"> • An intra-articular fracture • A fracture involving the growth plate • An open fracture 	Clinical Reasoning Selectivity	Referral
6 When managing a patient with a fracture or dislocation, communicate clearly with the patient and the family (especially when the patient is a child) regarding the procedure, possible complications, and recovery timelines.	Communication	Treatment
7 When preparing a patient with a fracture for transfer: a) Adequately immobilize the fracture and regularly reassess neurovascular status, including at transfer points b) Provide adequate analgesia c) Minimize the risk of pressure sores	Clinical Reasoning Procedures Skills Clinical Reasoning Clinical Reasoning	Treatment Treatment Treatment

See also: [Procedural sedation, Fractures](#)

Intrapartum care

Key Feature	Skill	Phase
1 During prenatal care, communicate early the benefits and risks of delivering locally versus at a distance.	Clinical Reasoning Patient-centred Approach	Treatment
2 When deciding on the location for delivery before or during labour, review important existing and evolving factors, such as: <ul style="list-style-type: none"> • Cultural preferences regarding birthing • Local resources • Weather • Patient's condition 	Patient-centred Approach Selectivity	Treatment
3 For any woman in late pregnancy or in labour, have a high index of suspicion for non-cephalic presentations and manage appropriately.	Clinical Reasoning	Hypothesis generation Treatment
4 When a fetus is in distress: <ul style="list-style-type: none"> a) Perform intrapartum resuscitative interventions b) Anticipate assisted vaginal delivery or surgical delivery 	Clinical Reasoning Clinical Reasoning	Treatment Treatment
5 For a pregnant or postpartum woman, assess for and manage eclampsia if present.	Clinical Reasoning	Diagnosis Treatment
6 After every delivery: <ul style="list-style-type: none"> a) Be prepared to manage postpartum hemorrhage b) Assess for the presence of lacerations, including a rectal exam when indicated c) Manage appropriately and identify those lacerations that require consultation 	Clinical Reasoning Clinical Reasoning Clinical Reasoning Procedures Skills	Treatment Diagnosis Treatment Treatment Referral
7 For all stable women and neonates, encourage and support breastfeeding, especially in regions with poor water quality.	Clinical Reasoning Patient-centred Approach	Treatment

See also: [Pregnancy](#) and [Priority Topics and Key Features for the Assessment of Competence in Intrapartum and Perinatal Care](#)

Altered level of consciousness

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a patient presenting with an altered level of consciousness:	<i>Clinical Reasoning</i>	<i>History</i>
a) Obtain a comprehensive history and perform a detailed clinical assessment		<i>Physical</i>
b) Quickly identify and manage common reversible causes (e.g., hypoglycemia, opioid overdose, sepsis, hypothermia)	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Treatment</i>
c) Identify the need for additional tests that may require patient transfer to another facility	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Investigation</i> <i>Referral</i>
d) Reassess frequently for any change in status	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i> <i>Follow-up</i>
2 When a patient with an altered level of consciousness presents in an agitated or aggressive state, optimize the safety of the patient and the staff.	<i>Professionalism</i>	<i>Treatment</i>

See also: [Loss of Consciousness](#) and [Dementia](#)

Procedural sedation

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When considering procedural sedation, recognize the difference between elective and emergent situations and obtain consent accordingly.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis Treatment</i>
2 When preparing for procedural sedation: a) Ensure adequate support and equipment, including a rapid sequence intubation protocol b) Select medications and equipment appropriate to the clinical presentation, considering personal knowledge and skill c) Always check the doses according to patient's weight, especially for children d) Consider airway protection for compromised patients	<i>Clinical Reasoning Clinical Reasoning Selectivity Clinical Reasoning Clinical Reasoning</i>	<i>Treatment Treatment Treatment Hypothesis generation Treatment</i>
3 When performing procedural sedation, anticipate, monitor for, and respond to potential complications (e.g., laryngospasm, hypoventilation, hypotension).	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 For a patient who has undergone procedural sedation, a) Ensure an adequate recovery observation period b) Ensure the patient is accompanied by a responsible person if they are being discharged	<i>Clinical Reasoning Clinical Reasoning Professionalism</i>	<i>Treatment Treatment</i>

See also: [Fractures](#) and [Lacerations](#)

Chronic pain in rural and remote settings

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a patient presenting with chronic pain, recognize that social determinants of health and previous conditions (e.g., trauma, abuse, addiction) may contribute to the pain syndrome.	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
2 When treating patients with chronic pain, optimize non-opioid medications and strive to provide non-pharmacological management (e.g., trauma-informed counselling, physiotherapy, splinting/bracing, joint and trigger point injections).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 When caring for a patient who has been prescribed opioids for chronic pain, use all resources available in the community (including the local pharmacy) to develop an effective local approach to prescribing that minimizes addiction potential, enhances treatment, and promotes safety.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>
4 When caring for patients with chronic pain in a rural or remote environment with difficult access to other resources, actively advocate for patients' access to services.	<i>Patient-centred Approach Professionalism</i>	<i>Treatment</i>

See also: [Pain](#) and [Chronic Pain](#)

Indigenous health

These key features may apply equally to other underserved rural and remote populations.

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When caring for Indigenous populations:	<i>Professionalism</i>	<i>Hypothesis generation</i>
a) Recognize personal prejudice, assumptions, and generalizations		
b) Consider local cultural norms of different population groups	<i>Patient-centred Approach</i>	<i>Hypothesis generation Treatment</i>
c) Recognize the systemic and individual effects of historical and ongoing government policies toward Indigenous populations and the impact these have on their health status	<i>Patient-centred Approach</i>	<i>History Treatment</i>
d) Take the necessary time to establish trust and find common ground	<i>Patient-centred Approach Communication</i>	<i>History Treatment</i>
e) Recognize the connection between poor health and social determinants of health, and actively advocate for patients' access to services	<i>Clinical Reasoning Professionalism</i>	<i>Hypothesis generation Treatment</i>
2 When assessing Indigenous patients, consider diseases that are prevalent in the local area (e.g., tuberculosis, water-related/environmental diseases, diseases related to traditional food sources).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 When caring for Indigenous populations, consider the impact of dental health, and educate patients and families about dental care.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Hypothesis generation Treatment</i>
4 When caring for Indigenous populations, consider the effect of the geographical location (e.g., amount of daylight, isolation, food access) on mental and physical health.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Hypothesis generation</i>
5 For Indigenous patients with suicidality, identify safe places and involve available supports.	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
6 When considering transfer for Indigenous patients, recognize the potential trauma related to leaving their community and treat locally when possible.	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment</i>

See also: [Professionalism](#) themes [3](#), [6](#), and [9](#), [Patient Centred Approach](#), [Suicide](#) and [Periodic Health Assessment/Screening](#)

Clinical courage

Key Feature	Skill	Phase
1 When dealing with a clinical situation that might surpass your level of comfort:		
a) Do not minimize the situation (e.g., underestimate the necessary level of skill, ignore the complexity of the situation to avoid dealing with it) and do not overreact (e.g., over transferring, over consulting)	Professionalism Clinical Reasoning	Treatment
b) Assess comprehensively, considering the resources, presentation, indications, and contraindications of proposed interventions	Clinical Reasoning Selectivity	Diagnosis Treatment
c) Develop a management plan	Clinical Reasoning Patient-centred Approach	Treatment
2 When considering an intervention that surpasses your level of comfort, be prepared to take a risk by:	Clinical Reasoning Professionalism	Treatment
• Drawing on your parallel education or knowledge		
• Anticipating difficulties and consulting when appropriate, seeking local and external support		
• Following a patient-centred approach and maintaining communication with the patient or advocate, in order to ensure that you are acting in their best interest		
3 After an encounter that was beyond your level of comfort, reflect, debrief with colleagues, and identify learning opportunities.	Professionalism Clinical Reasoning	Follow-up
4 When caring for a patient with an uncertain diagnosis in a rural or remote area where resources may be limited, recognize that repeated assessment over time will help provide reassurance that appropriate care is being provided.	Clinical Reasoning Patient-centred Approach	Follow-up

See also: [Professionalism](#), themes #[2](#),[3](#),[6](#) and [7](#)

Adapting to rural life

Developing a sensitivity to local culture and social norms provides a foundation for becoming familiar with your local community. Some individuals may adapt seamlessly, while others may have difficulty making the transition.

When working in a rural or remote environment:

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Recognize your own needs and the needs of your family in order to develop a sustainable and satisfying lifestyle.	<i>Professionalism</i>	
2 Remain aware of personal visibility in the community and the overlap between personal and professional life.	<i>Professionalism</i>	
3 Ensure patients' privacy, keeping in mind that the community is connected in ways of which you may not be aware.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
4 Be aware that creating and maintaining appropriate boundaries may be more challenging in rural environments.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
5 Actively participate in community life.	<i>Professionalism</i> <i>Communication</i>	
6 Consider maintaining academic connections with a medical school as a preceptor.	<i>Professionalism</i>	
7 Be prepared to share the administrative responsibilities of health care in your community (e.g., chief of staff, leadership roles, committee participation).	<i>Professionalism</i>	
8 Recognize a strong emotional response and possible post-traumatic stress in yourself and staff after treating a co-worker, friend, or family member, or after a traumatic medical or community event, and address it appropriately.	<i>Professionalism</i> <i>Communication</i>	
9 Establish safe supportive relationships with other health care professionals (including those from other communities) where difficult medical and social issues may be discussed in an informal manner (e.g., Balint group, problem-based small group learning, Society of Rural Physicians of Canada).	<i>Professionalism</i> <i>Communication</i>	
10 Have your own family physician	<i>Professionalism</i>	

See also: [Professionalism](#) themes [8](#), [10](#) and [11](#)

Cultural safety and sensitivity

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When providing health care in a rural or remote community, familiarize yourself with local traditions, beliefs, and habits, and recognize cultural differences in order to anticipate and prevent potential conflicts.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
2 When caring for patients in a rural or remote setting, remain aware of the already limited choices and resources available to the patients and that your values may further affect health care services provided in your community (e.g., opioid prescribing, birth control).	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
3 When caring for patients in a rural or remote community: a) Identify their priorities, expectations, and preferences (e.g., patient transfer, birth, palliative care and dying)	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
b) Demonstrate respect for important local practices (e.g., sweat lodge, smudge ceremony, cupping)	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Treatment</i>
c) Consider enlisting the assistance of people who are fluent in the patient's culture (e.g., minister, elder)	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Treatment</i>
4 When working in a community with a predominant ethnic or religious group, avoid generalizing and assuming that all community members share the same beliefs and create a safe place for all individuals.	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Treatment</i>

See also: Professionalism themes [3](#), [5](#), [6](#) and [10](#)

Priority Topics and Key Features for Intrapartum and Perinatal Care²¹

Priority Topics

- 1 [Normal labour and delivery](#)
- 2 [Fetal health surveillance during labour](#)
- 3 [Pain in labour](#)
- 4 [Labour dystocia](#)
- 5 [Vacuum assisted delivery](#)
- 6 [Vacuum assisted delivery—procedure skill](#)
- 7 [Shoulder dystocia](#)
- 8 [Shoulder dystocia—procedure skill](#)
- 9 [Postpartum hemorrhage](#)
- 10 [Perineal lacerations—procedure skill](#)
- 11 [Peripartum fever](#)
- 12 [Antepartum bleeding—after 20 weeks gestation](#)
- 13 [Non-cephalic fetal presentation](#)
- 14 [Pre-labour rupture of membranes](#)
- 15 [Preterm labour](#)
- 16 [Trial of labour after Caesarian](#)
- 17 [Induction of labour](#)
- 18 [Peripartum mental health](#)
- 19 [Gestational hypertension/preeclampsia](#)
- 20 [Gestational diabetes](#)
- 21 [Breastfeeding](#)
- 22 [First week of life](#)
- 23 [Working in teams](#)
- 24 [Limits—practising according to personal and facility limits](#)

²¹ Suggested citation: Biringer A, Ehman W, Fenton S, Gagnon A, Graves L, Miller K, Northorp S, et al. *Priority Topics and Key Features for the Assessment of Competence in Intrapartum and Perinatal Care*. Mississauga, ON: College of Family Physicians of Canada; 2017

Normal labour and delivery

Key Feature	Skill	Phase
1 When a woman ²² presents in labour, a) Assess for risk factors that identify those women for whom vaginal birth is not appropriate b) Establish the preferred expectations for the delivery with the woman and her supports	Clinical Reasoning Clinical Reasoning Patient-centred Approach	History Treatment History
2 When a woman presents in labour, a) Diagnose the stage and the phase of labour based on history and abdominal and pelvic exam b) Decide whether or not to admit based on appropriate medical, social, and personal factors in order to reduce premature admissions	Clinical Reasoning Clinical Reasoning Selectivity	Diagnosis Hypothesis generation
3 Throughout labour: a) Provide support and pain management, using a patient-centred approach and multiple options (e.g., mobility, different positions) b) Monitor maternal and fetal well-being, in order to recognize any changes that would alter the management plan c) Follow progress regularly d) Avoid unnecessary or premature interventions (e.g., using uterotonics when not in active labour)	Clinical Reasoning Patient-centred Approach Clinical Reasoning Clinical Reasoning Selectivity	Treatment Treatment Treatment Treatment
4 During the second stage of labour: a) Initiate pushing at the appropriate time, respecting the woman's preferred position and expulsive efforts b) Conduct a controlled delivery in order to minimize trauma	Clinical Reasoning Procedures Skills	Treatment Treatment
5 Immediately following vaginal birth: a) Care for the well newborn with skin-to-skin care, assessment, delayed cord clamping, and early initiation of breastfeeding b) Assess the need for resuscitation of the newborn and manage appropriately c) Assess uterine tone and bleeding, and administer prophylactic oxytocin in the third stage	Clinical Reasoning Clinical Reasoning Clinical Reasoning	Treatment Hypothesis generation Treatment Treatment

²² We are cognizant and respectful that not all pregnant individuals will identify with traditional gender roles. Our choice of the word "woman" to refer to the pregnant individual was chosen for consistency and ease throughout the document and is not intended to exclude those for whom this is not their chosen term.

Priority Topics and Key Features for Intrapartum and Perinatal Care

d) Deliver the placenta, avoiding unnecessary traction	<i>Procedures Skills</i>	<i>Treatment</i>
e) Assess and manage perineal injury	<i>Clinical Reasoning</i>	<i>Physical Exam Treatment</i>
<hr/>		
6 Following a vaginal delivery:	<i>Communication</i>	<i>Follow-up</i>
a) Debrief with the team, including the woman and her supports, and document appropriately		
b) Reassess the woman and baby, and review ongoing management plans before leaving the birthing unit	<i>Clinical Reasoning</i>	<i>Follow-up</i>
<hr/>		

Fetal health surveillance during labour

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>1 Whenever a woman presents in labour, assess the risk factors and the overall context to select and initiate the appropriate method, frequency, and timing of fetal surveillance (intermittent auscultation (IA) versus electronic fetal monitoring (EFM)):</p> <ul style="list-style-type: none"> • Assessment of risk factors and context must be current • In general, use IA for women without risk factors and EFM when risk factors are present • Ensure fetal surveillance is maintained as per a standard protocol 	<p><i>Clinical Reasoning</i> <i>Selectivity</i></p>	<p><i>Hypothesis generation</i> <i>Treatment</i></p>
<p>2 When reviewing the findings on fetal surveillance, always correlate fetal heart rate with uterine activity.</p>	<p><i>Clinical Reasoning</i></p>	<p><i>Treatment</i> <i>Investigation</i></p>
<p>3 When conducting fetal health surveillance during labour, classify and document the fetal surveillance as per standardized classification (i.e., normal, atypical, or abnormal).</p>	<p><i>Clinical Reasoning</i> <i>Communication</i></p>	<p><i>Diagnosis</i></p>
<p>4 When interpreting fetal surveillance,</p> <p>a) Look for and recognize the abnormalities, especially the subtle ones that require immediate action</p> <p>b) Act promptly to resolve the situation.</p>	<p><i>Clinical Reasoning</i></p> <p><i>Selectivity</i></p>	<p><i>Hypothesis generation</i></p> <p><i>Treatment</i></p>
<p>5 When abnormal or atypical fetal surveillance is observed:</p> <p>a) Interpret within the context of the whole pregnancy and labour (e.g., stage and progress of labour, maternal stability, maternal/fetal risk factors, duration of abnormalities)</p> <p>b) Assess for etiology and contributing factors</p> <p>c) Institute appropriate intrauterine resuscitation, and when abnormal fetal surveillance is not corrected by intrauterine resuscitation, institute a plan for delivery</p>	<p><i>Clinical Reasoning</i></p> <p><i>Clinical Reasoning</i></p> <p><i>Clinical Reasoning</i></p>	<p><i>Diagnosis</i></p> <p><i>Hypothesis generation</i></p> <p><i>Treatment</i></p>

Pain in labour

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Prior to labour, discuss pain and pain relief with women, correcting misconceptions and providing education.	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 For a woman in labour, use a patient-centred approach to clarify her pain experience and her emotional state, as well as her expectations and preferences for pain management.	<i>Patient-centred Approach</i>	<i>Treatment</i>
3 When managing pain for a woman in labour, optimize the use and effectiveness of support and other non-pharmacological measures (e.g., hydrotherapy, TENS, ambulation).	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 When providing pharmacological pain relief in labour, use an appropriate method (e.g., opiates, nitrous oxide, epidural anesthesia), taking into account the woman's choices, the stage of labour, available resources and possible side-effects (e.g., fetal surveillance changes, newborn respiratory depression, labour prolongation).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 For a woman using analgesia in labour, look for and manage side effects (e.g., maternal fever, fetal surveillance changes).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>
6 When pain in labour is unusual or unresponsive to typically effective management, assess to rule out unusual or pathological causes (e.g., uterine rupture, pulmonary embolus, history of sexual abuse) that would require other interventions or approaches.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Labour dystocia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a woman presents with possible labour, diagnose or rule out active labour, based on history and on abdominal and pelvic examination (i.e., avoid premature admission to labour and delivery).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 For a woman in labour: a) Assess and document progress of labour by following cervical dilation and fetal descent. b) Make a diagnosis of labour dystocia based on lack of progress in cervical dilation in the first stage of labour and fetal descent in the second stage, and in the context of maternal and environmental factors; avoid making the diagnosis too early or too late	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Diagnosis</i>
3 When labour dystocia is suspected, or diagnosed: a) First consider and use non-pharmacological methods to treat (e.g., ambulation, continuous support, amniotomy) b) Systematically look for and identify possible contributing factors (i.e., uterine contractility, fetal size and presentation, pelvic architecture, maternal pain and psychological state) in order to optimize management	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 For a woman with labour dystocia that has not responded to appropriate non-pharmacological intervention, use an appropriate uterotonic medication, while maintaining careful surveillance of maternal and fetal well-being.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
5 For a woman with labour dystocia, look for and recognize the fetal and maternal indications for operative delivery.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>

Vacuum assisted delivery

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a woman in labour, look for signs that she may need an assisted delivery (e.g., labour dystocia, atypical or abnormal fetal surveillance, maternal fatigue) and, when these signs are present, start the appropriate preparations, including a backup plan with additional help as necessary.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
2 When assisted delivery is contemplated, assess for contraindications (e.g., any presentation other than cephalic, cervix not fully dilated, unengaged head, < 34 weeks) and, when present, make appropriate alternative plans for delivery.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
3 When an assisted delivery is indicated, discuss the options with the woman, obtain informed consent, and prepare the team.	<i>Communication Patient-centred Approach</i>	<i>Treatment</i>
4 When performing an assisted delivery, use a standardized approach (e.g., the A to J mnemonic from ALARM).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 When an assisted delivery is not progressing as expected, do not persist with excessive efforts, but abandon the procedure and initiate the alternative backup delivery plan.	<i>Selectivity</i>	<i>Treatment</i>
6 Following an assisted delivery, examine the woman and the newborn for signs of trauma (e.g., high vaginal laceration, third-degree tear, subgaleal bleeding) or need for further care.	<i>Clinical Reasoning</i>	<i>Physical Exam Follow-up</i>
7 At the appropriate time following an assisted delivery, debrief with the woman (and her supports), and with the team. Document thoroughly.	<i>Communication</i>	<i>Follow-up</i>

See also [General Key Features of Procedure Skills](#) for Family Medicine for technical aspects.

Vacuum assisted delivery—procedure skill

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When considering a vacuum assisted delivery, confirm full cervical dilatation and assess the station and position of the head to ensure that the procedure is safe and likely to succeed.	<i>Procedures Skills</i>	<i>Treatment</i>
2 Prior to placing the vacuum, optimize the chance of success by ensuring adequate analgesia, emptying the woman’s bladder, and engaging the woman and her supports in the procedure. Check that the equipment is working and that a backup plan is in place.	<i>Procedures Skills Communication</i>	<i>Treatment</i>
3 When applying the vacuum cup, ensure that the position is correct, there is no entrapment of maternal tissue, and appropriate vacuum pressure is being applied.	<i>Procedures Skills</i>	<i>Treatment</i>
4 When performing a vacuum assisted delivery, apply traction during maternal pushing and pull firmly but not excessively, without pivoting. Apply traction in the direction of the pelvic curve, initially downward and finally upward.	<i>Procedures Skills</i>	<i>Treatment</i>
5 When applying traction, assess descent on each pull. Reassess the plan if there are indications that the procedure will not succeed: <ul style="list-style-type: none"> • No progress after two pulls with a properly positioned cup and good traction • Three pop-offs without obvious cause • Delivery not imminent after four contractions • Delivery not imminent after 20 minutes of vacuum application 	<i>Procedures Skills</i>	<i>Hypothesis generation Treatment</i>

Note: See also [General Key Features of Procedure Skills](#) for Family Medicine for technical aspects.

Shoulder dystocia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For all deliveries, assess risk factors for shoulder dystocia, develop a plan of management according to the risks, and adjust the preparations according to the evolving risks.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
2 For all deliveries, anticipate and remain vigilant for the signs of impending shoulder dystocia and, when appropriate, prepare the woman and the team for the possibility of shoulder dystocia.	<i>Selectivity Communication</i>	<i>Hypothesis generation Treatment</i>
3 During the second stage of labour, recognize shoulder dystocia promptly when it occurs, communicate its presence clearly to the team, including the woman, and, working as a team, use appropriate manoeuvres to resolve it.	<i>Clinical Reasoning Communication</i>	<i>Diagnosis Treatment</i>
4 After the shoulder dystocia is resolved: a) Examine the mother and the newborn for signs of trauma	<i>Clinical Reasoning</i>	<i>Physical Exam Follow-up</i>
b) Debrief with the team, including the woman and her supports	<i>Communication</i>	<i>Follow-up</i>
c) Document the manoeuvres used and the timing of events (including head to shoulder time)	<i>Communication</i>	<i>Follow-up</i>

Note: See also [General Key Features of Procedure Skills](#) for Family Medicine for technical aspects.

Shoulder dystocia—procedure skill

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a shoulder dystocia occurs, inform the team (including the woman), call for additional assistance, and immediately implement an accepted algorithm to resolve the dystocia.	<i>Procedures Skills</i> <i>Communication</i>	<i>Treatment</i>
2 When managing a shoulder dystocia, avoid actions that may increase the shoulder impaction (e.g., pressure on the fundus, maternal pushing when the shoulder remains impacted) or that may injure the baby (e.g., traction on the head, pivoting the head to rotate the shoulders). Coach the woman to push only when instructed.	<i>Procedures Skills</i>	<i>Treatment</i>
3 When managing a shoulder dystocia, use a systematic approach that includes: <ul style="list-style-type: none"> • External manoeuvres: hyperflexion of the hips (McRoberts), suprapubic pressure on the anterior shoulder, all fours position • Internal manoeuvres: shoulder rotations (Rubin, Woods, delivery of posterior arm • Episiotomy if required to perform internal manoeuvres 	<i>Procedures Skills</i>	<i>Treatment</i>
4 When managing a shoulder dystocia, complete one manoeuvre before encouraging more maternal pushing. Then, if it does not work, move rapidly to the next manoeuvre before the next pushing effort.	<i>Procedures Skills</i>	<i>Treatment</i>
5 If initial manoeuvres are unsuccessful, repeat them, perfecting the technique, and focusing on the manoeuvres that are most likely to be successful (e.g., removal of posterior arm, changing maternal position). Call for additional assistance.	<i>Procedures Skills</i>	<i>Treatment</i>

Note: See also [General Key Features of Procedure Skills](#) for Family Medicine for technical aspects.

Postpartum hemorrhage

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For all pregnant women, identify risk factors for postpartum hemorrhage (PPH; e.g., grand multiparous, prolonged labour, anticoagulants) and prepare accordingly.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
2 Manage the third stage of labour with a prophylactic uterotonic, consideration of controlled cord traction, and assessment of uterine tone after placental delivery.	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 Following all births, closely monitor for ongoing blood loss (both visible and occult) in order to accurately estimate the total blood loss, and to promptly recognize and diagnose a PPH.	<i>Clinical Reasoning</i>	<i>Follow-up</i>
4 When a diagnosis of PPH is made:	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
a) Identify whether the woman is stable or unstable and adjust management accordingly	<i>Selectivity</i>	<i>Treatment</i>
b) Activate the team early to provide extra support	<i>Communication</i>	<i>Treatment</i>
c) Look for correctible etiologies, in order to treat, specifically	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
• Poor uterine tone (uterotonics)		
• Retained products of conception (remove)		
• Trauma (repair)		
• Distended bladder (urinary catheter)		
• Coagulation deficit (correct)		
d) Monitor closely to anticipate and recognize the need for further intervention	<i>Clinical Reasoning</i>	<i>Follow-up</i>
5 For a PPH that has stabilized, continue to monitor over an extended period until recurrence is unlikely.	<i>Clinical Reasoning</i>	<i>Follow-up</i>
6 For a woman who has had a PPH, provide counselling for subsequent pregnancies.	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Perineal lacerations—procedure skill

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 After every delivery, assess for the presence, location, and degree of perineal laceration, including a rectal exam when appropriate. Distinguish between those that need repair and those that do not.	<i>Procedures Skills</i>	<i>Treatment Diagnosis</i>
2 When a perineal laceration occurs: a) Ensure that optimal conditions (e.g., assistance, lighting, retraction, hemostasis, analgesia) are present for assessment and repair	<i>Procedures Skills</i>	<i>Treatment</i>
Identify complicated perineal injury (e.g., third- or fourth-degree tear, high vaginal laceration) and consider the need for assistance or consultation for the repair	<i>Procedures Skills</i>	<i>Treatment Diagnosis</i>
Repair lacerations using techniques that will reduce the risk of complications (e.g., bleeding, infection, incontinence, pain)	<i>Procedures Skills</i>	<i>Treatment</i>
3 In the presence of a second-degree perineal laceration, repair using a systematic approach that includes: <ul style="list-style-type: none"> • Identifying key anatomic structures—apex of laceration, hymenal ring, perineal muscles, intact anal sphincter • Securing the apex and aligning the hymen and the perineal body, then suturing the vaginal mucosa from apex to hymen • Suturing the perineal muscles • Suturing the skin or planning to let heal by secondary intention 	<i>Procedures Skills</i>	<i>Treatment</i>
4 Following the repair of perineal laceration, re-examine for completeness of repair and hemostasis. This may include a rectal examination.	<i>Procedures Skills</i>	<i>Treatment</i>

Note: See also [General Key Features of Procedure Skills](#) for Family Medicine for technical aspects.

Peripartum fever

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a labouring or postpartum woman has a fever, determine whether the cause is an infection (e.g., chorioamnionitis, endometritis, pyelonephritis) or not (e.g., epidural, work of labour), and re-evaluate the diagnosis regularly.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 When a labouring or postpartum woman has a suspected infection:		
a) Anticipate the possible impacts of the infection on the woman and the fetus/neonate	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
b) Conduct appropriate investigations, maternal monitoring, and fetal surveillance or newborn assessment	<i>Clinical Reasoning</i>	<i>Investigation</i>
c) Initiate treatment without delay	<i>Selectivity</i>	<i>Treatment</i>
3 When chorioamnionitis is suspected, treat empirically and aggressively (e.g., IV broad-spectrum antibiotics), even for those who have received GBS antibiotic prophylaxis, and formulate a plan for delivery.	<i>Selectivity</i>	<i>Treatment</i>
4 For all postpartum women:		
a) Identify those at higher risk of infection (e.g., long labour, Caesarean section)	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
b) Recognize early signs of infection	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
c) Advise regarding symptoms and when to seek care	<i>Clinical Reasoning Communication</i>	<i>Treatment</i>

Antepartum bleeding—after 20 weeks gestation

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For a woman presenting with antepartum bleeding, first assess the stability of both the woman and the fetus, as urgent management must begin for unstable patients before the exact cause of the bleeding has been confirmed.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 If the woman with antepartum bleeding is unstable or if there is suspected fetal compromise		
a) Resuscitate immediately	<i>Selectivity</i>	<i>Treatment</i>
b) Mobilize the necessary resources for urgent delivery	<i>Communication</i>	<i>Treatment</i>
c) Monitor the situation	<i>Clinical Reasoning</i>	<i>Treatment</i>
d) Identify the cause of the bleeding	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
3 While managing a woman with antepartum bleeding, assess to diagnose the cause of the bleeding, using methods that minimize risks of harm, to recognize potentially life threatening causes: <ul style="list-style-type: none"> • Obtain history (e.g., onset, quantity of bleeding, presence of pain, trauma) • Determine placental location by ultrasound (previous or current) prior to vaginal exam (do not perform vaginal exam unless placenta previa is ruled out) • Assess the uterus (e.g., activity, tone, tenderness) and fetal well-being • Use other diagnostic techniques as indicated (e.g., speculum exam) 	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
4 For a woman with antepartum bleeding who is stable with normal fetal surveillance, provide ongoing assessment and management based on the diagnosis and the gestational age (e.g., manage Rh status, administer corticosteroids for fetal lung maturity). Decide whether hospitalization or transfer is indicated and the likely mode of delivery.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Diagnosis</i>
5 Following a resolved episode of antepartum bleeding, inform the woman and her supports about the risks of antepartum bleeding in current and in subsequent pregnancies, and about strategies to minimize the risk.	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Non-cephalic fetal presentation

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 For any woman in the third trimester or in labour, determine the exact fetal presentation using appropriate techniques (e.g., Leopold's manoeuvres, vaginal exam if indicated, ultrasound).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 When a non-cephalic presentation has been identified pre-labour, discuss, with the woman and her supports, alternative plans or possibilities for delivery (e.g., external cephalic version, trial of labour, planned Caesarean section) according to the presentation. Inform the woman of possible complications (e.g., cord prolapse) and appropriate actions.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
3 When a non-cephalic presentation is identified in labour, discuss the delivery options with the woman, while seeking consultation and team support as necessary, and while initiating preparations for a possible Caesarian section.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
4 When facilitating an imminent unavoidable breech delivery, optimize the process by avoiding traction on the fetus, ensuring that the back remains up, and ensuring head flexion through delivery.	<i>Procedures Skills</i>	<i>Treatment</i>
5 After a vaginal breech delivery, anticipate that the newborn is more likely to require resuscitation.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Pre-labour rupture of membranes

Key Feature	Skill	Phase
1 For pregnant women presenting with vaginal fluid loss, look for and diagnose pre-labour rupture of membranes using history, abdominal exam to verify presentation, speculum exam (avoid doing vaginal examination unless indicated for management), and fluid inspection and analysis (e.g., nitrazine, ferning test).	Clinical Reasoning	Hypothesis generation Diagnosis
2 For a woman with signs and symptoms suggestive of pre-labour rupture of membranes (PROM) but negative confirmatory tests, do not exclude the possibility of PROM, and plan appropriate fetal/maternal surveillance for signs of fever and/or infection.	Clinical Reasoning Selectivity	Hypothesis generation Treatment
3 For all women with PROM at term, rule out contraindications to vaginal delivery, and, if there are no contraindications, offer induction of labour through an informed discussion within the context of risk factors (e.g., GBS status), patient preference, and system demands (e.g., staffing availability).	Clinical Reasoning	History Treatment
4 In a woman with PROM in whom labour has not been induced: a) Monitor for signs of infection (e.g., fever, fetal tachycardia, odour) even for those patients on prophylactic antibiotics	Clinical Reasoning	Diagnosis
b) Treat suspected or confirmed chorioamnionitis aggressively and early (e.g., IV antibiotics), and do not rely on the previous prophylactic treatment	Selectivity	Treatment
5 In a woman with preterm PROM: a) Initiate treatment as per local protocol (e.g., admission, steroids, IV antibiotics, and monitoring)	Clinical Reasoning	Treatment
Plan appropriate definitive treatment depending on gestational age and the capacity of the facility and team, and considering the indications for consultation or for transfer to another care facility	Clinical Reasoning	Referral
6 When a baby is born after pre-labour rupture of membranes, assess for signs of sepsis, and initiate treatment promptly if sepsis is suspected.	Clinical Reasoning Selectivity	Treatment

Preterm labour

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When assessing a pregnant woman who is not in labour, look for risk factors for premature labour, and manage the treatable factors to reduce risk whenever possible.	<i>Clinical Reasoning</i>	<i>History Treatment</i>
2 When caring for a pregnant woman who is not in labour, educate her and her supports about signs and symptoms of preterm labour and how to seek help.	<i>Clinical Reasoning Communication</i>	<i>Treatment</i>
3 For a woman presenting in suspected preterm labour, confirm the presence or absence of labour, using appropriate techniques (e.g., assessment of contractions, sterile speculum exam, fetal fibronectin, cervical assessment).	<i>Clinical Reasoning</i>	<i>Investigation</i>
4 For a woman in preterm labour, manage according to the gestational age and fetal surveillance to minimize neonatal morbidity and mortality by: <ul style="list-style-type: none"> • Mobilizing the team to ensure availability of resources, including early consultation, that may be needed for the mother and the infant • Administering appropriate medications (e.g., antenatal corticosteroids, tocolytics, antibiotics, magnesium sulphate) • Arranging for transfer if necessary, at the appropriate time 	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Following the birth of a preterm infant, particularly one who requires intensive care, provide support and advocacy for the woman and family, in the context of an ongoing therapeutic relationship.	<i>Communication Patient-centered Approach</i>	<i>Treatment Follow-up</i>

Trial of labour after Caesarian

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a woman who has had a Caesarean section, assess the risks and benefits of a trial of labour after Caesarian (TOLAC) and discuss in order to identify those who are good candidates, those who are not good candidates, or where it would be contraindicated. Document the discussion, including risks and benefits identified.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
	<i>Communication</i>	<i>Treatment</i>
2 For a woman who is a candidate for TOLAC, offer TOLAC and help her make an informed decision by fully discussing the risks and advantages while showing flexibility and understanding of her preferences and concerns.	<i>Clinical Reasoning</i>	<i>Treatment</i>
	<i>Patient-centered Approach</i>	
3 In a woman who has had a Caesarean section and who goes into labour, be flexible in the management approach and adapt it to the circumstances, while still respecting the plans and preferences of the woman as much as possible (e.g., manage a spontaneous precipitous labour in a woman who had planned a repeat Caesarean section, discuss conversion of a planned TOLAC to a Caesarean section).	<i>Clinical Reasoning</i>	<i>Treatment</i>
	<i>Patient-centered Approach</i>	
4 Before planning or managing a TOLAC, ensure that the resources necessary for an unexpected immediate operative delivery are available and in place, ensure that the woman and her supports are well prepared for the complications that could necessitate this eventuality, and that all discussions and decisions about the TOLAC have been fully documented.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
	<i>Communication</i>	<i>Treatment</i>
5 For a woman choosing a TOLAC, provide appropriate maternal and fetal surveillance, close monitoring of the progress of labour, and careful use of induction and uterotonics if indicated.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 When managing a TOLAC, carefully assess maternal and fetal well-being and recognize any signs of imminent or actual uterine rupture requiring maternal and fetal resuscitation and urgent conversion to Caesarean section if needed.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>

Induction of labour

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When considering induction of labour, specifically assess the factors that will influence the decision (e.g., accurate expected date of delivery, indications, contraindications, cervical ripeness, maternal preference) and document the factors clearly to provide justification for decisions.	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Diagnosis</i> <i>Treatment</i>
2 When planning induction of labour:		
a) Induce labour only when there is a compelling and convincing indication and no contraindication	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Prioritize and schedule the induction based on indication and resources	<i>Selectivity</i>	<i>Treatment</i>
c) Select the facility with appropriate resources to manage fetal and maternal needs	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 When recommending induction of labour, obtain and document clear and detailed informed consent from the woman for accepting or declining the induction.	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Treatment</i>
4 When inducing labour:		
a) Select the appropriate method of cervical ripening (e.g., balloon catheters, prostaglandins) and/or induction (e.g., prostaglandins, oxytocin), based on obstetrical and medical history, Bishop score, patient preference, and team considerations.	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Assess the effect of the induction on maternal and fetal well-being.	<i>Clinical Reasoning</i>	<i>Treatment</i>
c) Select women for whom the outpatient management of cervical ripening is appropriate.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 During induction of labour, look for and manage complications of induction (e.g., tachysystole, abnormal fetal surveillance).	<i>Clinical Reasoning</i>	<i>History</i> <i>Treatment</i>
6 When a selected method of induction is unsuccessful, modify the management plan accordingly.	<i>Clinical Reasoning</i>	<i>Treatment</i>

Peripartum mental health

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Enquire about the mental health of all women throughout the peripartum period, assessing to identify discrete signs or symptoms or factors leading to a higher risk (e.g., substance abuse, intimate partner violence, previous mental health disorder, history of sexual abuse), and add an appropriate mood assessment tool (e.g., Edinburgh Postnatal Depression Scale, Generalized Anxiety Disorder scale) when indicated.	<i>Clinical Reasoning</i>	<i>History</i>
2 When concerns are raised about mental health in the peripartum period, actively explore the situation with the woman and her supports, and provide education about normal and common psychological changes during pregnancy, as well as the signs that may suggest a mental health disorder.	<i>Clinical Reasoning</i>	<i>History Treatment</i>
3 For women in the peripartum period with an apparent mental health disorder, assess to rule out possible underlying causative or contributing medical conditions (e.g., anemia, thyroid dysfunction).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
4 For a woman with a mental health disorder in the peripartum period, determine the risk of harm to self, infant, or others. When this risk is present, ensure urgent management to reduce the risk of harm. Educate the woman and her supports regarding a possible rapid escalation of symptoms, and available resources.	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
5 For a woman with a mental health disorder in the peripartum period: a) Maintain the therapeutic relationship, provide counselling, refer to the available resources, and advocate for rapid access when needed b) Use medication if indicated, balancing the risk of untreated mental health issues against the risk of medications to the fetus or newborn, and recognizing the benefits of continued breastfeeding if desired	<i>Communication</i> <i>Clinical Reasoning</i>	<i>Treatment Referral</i> <i>Treatment</i>

Gestational hypertension/preeclampsia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 At the beginning of all pregnancies, identify and assess the risk factors for gestational hypertension/preeclampsia and consider initiating preventive therapy for those at high risk.	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
2 Consider the diagnosis of preeclampsia at prenatal visits, even if the blood pressure is not obviously elevated, and especially when the woman has new poorly-defined constitutional symptoms.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 When preeclampsia is suspected, look for confirmatory evidence (symptoms, signs, basic investigations) to establish or rule out the diagnosis. Classify according to current nomenclature and re-assess regularly for progression of disorder.	<i>Clinical Reasoning</i>	<i>Diagnosis Treatment</i>
4 For gestational hypertension or non-severe preeclampsia, follow closely and manage according to maternal and fetal well-being and gestational age.	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
5 For a woman with a diagnosis of preeclampsia with adverse conditions or severe preeclampsia, manage actively by: <ul style="list-style-type: none"> • Initiating MgSO₄ in a timely fashion and other medications as appropriate (e.g., anti-hypertensives) • Assessing the need for prompt delivery, and arranging for delivery and/or consultation when indicated 	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 For any woman with gestational hypertension or preeclampsia who has delivered, continue management and monitor for progression or complications throughout the postpartum period.	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Gestational diabetes

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all pregnant women, screen for gestational diabetes using the appropriate test at the appropriate gestational age, and interpret the results according to guidelines for gestational diabetes (i.e., not regular diabetic guidelines).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 For a woman with gestational diabetes, plan for blood glucose control to avoid extremes of hyperglycemia and hypoglycemia, and do not confuse treatment targets and guidelines with those for non-gestational diabetes.	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 For a pregnant woman who is receiving specific care for diabetes (gestational or pre-gestational) from other providers, maintain your planned antepartum care for the patient, and integrate the recommended diabetic care into the overall management plan.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
4 When caring for a woman with gestational diabetes, closely monitor fetal growth and well-being (e.g., ultrasound, non-stress tests), as well as the maternal status, in order to recognize indications for induction.	<i>Clinical Reasoning</i>	<i>Follow-up</i>
5 When providing intrapartum care to a woman with gestational diabetes:		
a) Anticipate potential fetal macrosomia and if present, anticipate and plan for labour dystocia and shoulder dystocia	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Manage blood sugars actively, using insulin when indicated for optimal care, continuing as necessary into the postpartum	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 Following a gestational diabetic's delivery:		
a) Monitor the newborn closely for hypoglycemia, in the immediate postpartum period	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Plan to include screening for diabetes in the postpartum care of the woman	<i>Clinical Reasoning</i>	<i>Follow-up</i>

Breastfeeding

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 During prenatal care, enquire about newborn feeding plans. Promote exclusive breastfeeding, help establish reasonable expectations, and provide adequate information to develop a plan for feeding that respects the mother's preferences and informed choice.	<i>Clinical Reasoning</i> <i>Patient-centered Approach</i>	<i>History</i> <i>Treatment</i>
2 For a woman who is not breastfeeding her newborn, provide support for her decision, and provide information about feeding with human milk substitute.	<i>Clinical Reasoning</i> <i>Patient-centered Approach</i>	<i>Treatment</i>
3 For all pregnant women, assess and, when indicated, examine for issues that may affect breastfeeding (e.g., inverted nipples, previous surgery), and suggest interventions and resources.	<i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i>
4 For all births, including Caesarean section, facilitate early skin-to-skin contact and a comfortable and effective latch.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 When breastfeeding is challenging, first assess the latch and determine whether it is effective, and then look for other barriers to successful breastfeeding (e.g., lack of support, postpartum depression, breast pain, tongue tie, prematurity).	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical exam</i>
6 When any concerns or difficulties with breastfeeding arise, especially in the immediate newborn period, facilitate early access to suitable professional support.	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Referral</i>
7 Facilitate the continuation of breastfeeding when conditions arise, such as: <ul style="list-style-type: none"> • The woman has a breast infection or a nipple lesion • The woman or newborn requires medications, investigations, or hospitalization 	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 When a newborn/infant is exclusively breastfed, educate the family regarding normal weight gain, stool and voiding patterns, and how to assess the adequacy of feeding.	<i>Clinical Reasoning</i>	<i>Treatment</i>

First week of life

<i>Key feature</i>	<i>Skill</i>	<i>Phase</i>
1. When caring for newborns:		
a) Look for and recognize the subtle signs that they may be unwell (e.g., respiratory status, colour, tone, feeding), assess for etiology (e.g., hypoglycemia, maternal drug effect, sepsis) and arrange for diagnostic tests and ongoing care.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
b) Identify those who appear well but may be at a higher risk of complications (e.g., infant of diabetic woman, intrapartum infection, operative birth, drug withdrawal, social stressors), in order to plan close observation and management.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
c) Perform a thorough physical examination (e.g., palate, pulses, heart sounds, hips, testes, anus) to detect congenital abnormalities.	<i>Clinical Reasoning</i>	<i>Physical exam</i>
2. Prior to discharging any newborn, ensure the following:	<i>Clinical Reasoning</i>	<i>Treatment</i>
o Adequate feeding plan has been established		
o Newborn screening (e.g., bilirubin, metabolic, hearing test) has been completed or arranged		
o Family has been educated regarding care of the newborn (e.g., car seat, infant sleeping, acceptable weight loss) respecting cultural differences		
o Follow-up has been planned with a health care professional within a few days of discharge, especially for firstborns, families with psychosocial stressors, or if there were any perinatal issues		
3. When the parents (or other caregivers, including health care professionals) of a newborn express concern that the baby is unwell, listen carefully, and fully assess the baby to detect any subtle indicators of serious illness (e.g., sepsis).	<i>Selectivity</i>	<i>Diagnosis</i>

Working in teams in intrapartum care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Acknowledge all team members (including the patient and her supports) and as well as their roles and contributions, and respectfully listen to and respond to others' opinions, especially when they differ from your own.	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
2 Promote collaboration by accepting and giving help where required, contribute where most useful even when not in primary roles, and follow the leadership of others or assume the leadership for a defined period or situation.	<i>Professionalism</i>	<i>Treatment</i>
3 Respect the professional autonomy of the individual members of the team, while promoting collaborative decisions and actions for the benefit of the patient.	<i>Professionalism</i>	<i>Treatment</i>
4 When a team is working under difficult conditions, try to promote and maintain the effectiveness of the team by remaining calm, helping others in their roles and tasks whenever appropriate, resolving differences actively by considering the best interests of the patient, and by inspiring confidence whenever possible.	<i>Professionalism</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
5 Maintain clear verbal and written communications (including documentation), confirm that the information has been received (closed loop), and facilitate the participation of all in debriefing sessions.	<i>Communication</i>	<i>Treatment</i>

Limits—practising according to personal and facility limits

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a woman requires care that is beyond your personal or facility limits, advocate firmly to obtain this care in a timely fashion from an appropriate resource.	<i>Professionalism</i>	<i>Treatment</i>
2 Whenever the clinical course of a woman is not going as expected, review the provisional diagnosis and management plan, consider alternatives, and change if necessary (e.g., regularly reassess/re-evaluate potentially unstable patients, reflect on your clinical decisions).	<i>Clinical Reasoning</i>	<i>Treatment</i>
3 Whenever you recognize that a diagnosis or management plan needs to be modified:		
a) Seek additional information or help without delay.	<i>Clinical Reasoning</i>	<i>Referral</i>
b) Discuss the changes with the woman, her supports, and the team.	<i>Communication</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
c) Document the changes and the discussion.	<i>Communication</i>	<i>Treatment</i>
4 When caring for pregnant women, reflect on clinical experiences to identify gaps in clinical skills, and close those gaps with self- or group-learning.	<i>Professionalism</i>	<i>Diagnosis</i> <i>Treatment</i>
5 After an unexpected or unusual event, debrief effectively with appropriate team members, including the woman and her supports.	<i>Communication</i>	<i>Follow-up</i>

Priority Topics and Key Features for the Assessment of Competence in Mental Health

Out of the 24 priority topics developed by the Working Group on the Assessment of Competence in Mental Health, 16 overlapped with the existing topics for family medicine and were used to update their key features (see Part III).

The remaining topics are listed here as a resource.

1. [Bipolar disorder](#)
2. [Comorbid illnesses in mental health context](#)
3. [Developmental disability and delay](#)
4. [Family and circle of support in mental health context](#)
5. [Screening and early detection of mental health problems](#)
6. [Teamwork in mental health](#)
7. [Trauma informed care](#)
8. [Using community mental health resources](#)

Bipolar disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In any patient with depression, consider the possibility of bipolar disorder. Ask about family history, past symptoms and episodes.	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
2 Recognize that standard antidepressant treatment in a person with possible bipolar disorder may trigger mania or rapid mood cycling. Monitor closely.	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
3 1 When considering a diagnosis of bipolar disorder, a) Assess fully for other diagnostic possibilities such as substance use, post-traumatic stress disorder, situational duress or personality disorder	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
b) Avoid applying the diagnostic label too early, especially in younger patients	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
c) Consider consultation if the diagnosis is uncertain	<i>Clinical Reasoning Communication</i>	<i>Referral</i>
4 When caring for a patient with bipolar disorder, a) Maintain a strong therapeutic relationship in order to negotiate adequate treatment during episodes of increasing symptoms	<i>Professionalism Patient-centred Approach</i>	<i>Follow-up</i>
b) Look for and recognize the indicators of impending crisis and need for intervention, including involuntary treatment when appropriate	<i>Clinical Reasoning Selectivity</i>	<i>History Treatment</i>
c) Negotiate and plan proactive care for relapse and recovery which may include involvement of others	<i>Communication Patient-centred Approach</i>	<i>Treatment Follow-up</i>
d) Monitor response to and side effects of medication	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
e) Monitor and manage self medicating with alcohol or substances	<i>Clinical Reasoning Patient-centred Approach</i>	<i>Treatment Follow-up</i>

See also: [Depression](#)

Comorbid illnesses in mental health context

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 At every medical encounter inquire about both the patient's physical and mental health in order to provide proactive 'whole person' care.	<i>Patient-centred Approach</i>	<i>History</i>
2 When caring for a patient with mental health/alcohol or substance use problems consider medical co-morbidities and, <ol style="list-style-type: none"> a) Monitor the impact of the treatment on the person's overall health (e.g. medications for schizophrenia causing increased cardiovascular risk). b) Ensure their access to preventive care and medical services c) Pay attention to the effects of stress and adversity on cardio-metabolic risk d) Assess the impact of acute and chronic pain e) Identify specific risk factors for illness (e.g. smoking, obesity, sleep apnea) 	<i>Clinical Reasoning</i> <i>Professionalism</i> <i>Patient-centred Approach</i> <i>Patient-centred Approach</i> <i>Patient Centre</i> <i>Clinical Reasoning</i>	<i>Follow-up</i> <i>Treatment</i> <i>Referral</i> <i>Hypothesis generation</i> <i>Follow-up</i> <i>History</i> <i>History</i>
3 When a comorbid illness is diagnosed in a patient with mental health/alcohol or substance use problems: <ol style="list-style-type: none"> a) Clearly communicate the diagnosis, treatment plan and relevant information. Answer questions and involve the patient in their care. b) Recognize that they have the same interest in their medical problems as any other patient, but more time and support may be required to understand and process information c) Facilitate access to care and effectively coordinate treatment with other available services in order to mitigate system barriers and stigma d) Monitor progress, maintain the therapeutic alliance and clarify your own role in their ongoing care 	<i>Communication</i> <i>Patient-centred Approach</i> <i>Professionalism</i> <i>Patient-centred Approach</i> <i>Professionalism</i> <i>Communication</i> <i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Diagnosis</i> <i>Treatment</i> <i>Diagnosis</i> <i>Treatment</i> <i>Referral</i> <i>Follow-up</i>
When caring for patients with a chronic illness routinely inquire about the impact of medical problems on their life, family, mood and anxiety level. Recognize that depressed mood and anxiety can be a consequence of medical problems.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Follow-up</i>

Developmental disability and delay

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When caring for children, regularly and systematically assess physical and neuropsychological development, to facilitate the early detection and management of developmental problems.	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i>
2 When parents are concerned about a child's development even after an assessment with no evidence of developmental delay, plan regular reviews to: <ul style="list-style-type: none"> • assess the child's development over time • pay special attention to the child's mental health • explore the impact on the family 	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Follow-up</i>
3 For a child whose development shows variation from expectations, regularly reassess their physical and mental health. Look for possible causes with a particular emphasis on those that may be reversible or treatable.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>History</i> <i>Hypothesis generation</i>
4 When concerns are raised about a child's development or behaviour, with parental consent, seek information from all those caring for the child (e.g. parents, daycare, school).	<i>Clinical Reasoning</i> <i>Communication</i>	<i>History</i>
5 When a developmental problem is suspected, or identified in a child, develop a management plan with the parents that includes appropriate: <ul style="list-style-type: none"> • use of community support services • consultation services or specialized treatment • follow-up to monitor progress and ongoing or new concerns • attention to puberty and adolescent transition 	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
6 When providing care for an adult with developmental disability, establish a means of communication that facilitates: <ul style="list-style-type: none"> + building a trusting relationship + assessment of behaviour changes + assessment of physical and mental health + personal care planning over the long term 	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>Follow-up</i>

Family and circle of support in mental health context

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When providing care to a patient with mental health and addiction problems seek to understand who is “family” and/or the patient’s “circle of support”.	<i>Patient-centred Approach</i>	<i>History</i>
2 When a patient decides to exclude family from the circle of support, ascertain the reasons and address when appropriate.	<i>Patient-centred Approach</i>	<i>History</i>
3 When considering communication with the family or circle of support, obtain the consent of the patient or mandated substitute, respecting their rights to privacy and confidentiality.	<i>Communication</i> <i>Professionalism</i>	<i>History</i> <i>Treatment</i>
4 When providing care to a patient with mental health and alcohol and substance use problems: a) assess the impact of the patient’s illness on the family, b) assess the impact of the family on the patient’s illness c) assess the capacity of the family to contribute to the care, and the family’s need for support d) review the situation regularly	<i>Patient-centred Approach</i> <i>Patient-centred Approach</i> <i>Patient-centred Approach</i> <i>Clinical Reasoning</i> <i>Patient-centred Approach</i> <i>Clinical Reasoning</i>	<i>History</i> <i>History</i> <i>History</i> <i>Treatment</i> <i>Follow-up</i>
5 When working with a family for the ongoing care and recovery of a patient, a) Set clear goals for meetings with family and remain flexible in order to gather unplanned or unexpected information b) Find a balance between collective and individual interventions and decisions c) Recognize family relationships are complex and members may respond differently	<i>Selectivity</i> <i>Patient-centred Approach</i> <i>Patient-centred Approach</i> <i>Professionalism</i> <i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>Treatment</i> <i>Treatment</i>
6 Identify needs for specific intervention or support for the family members of a patient. If appropriate, provide or arrange for this intervention in a timely fashion, while paying attention to privacy, boundary, and ethical issues.	<i>Professionalism</i> <i>Patient-centred Approach</i>	<i>History</i> <i>Treatment</i>
7 When family therapy is indicated, determine the optimal resource according to the goals of therapy, the level of expertise required, the resources available, boundary issues, and family preferences.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Referral</i>
8 When concerns about a patient or a family member are raised by proxy, develop a management plan only after a full assessment of the situation, including: + the presence of safety issues, particularly for children and other vulnerable people + the family situation from the proxy’s and the patient’s point of view, + the presence of mental health problems, alcohol or	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>History</i> <i>Treatment</i>

substance use and other health issues

- + the availability of appropriate community or referral resources
- + ethical considerations and individual rights

9	When providing care for more than one family member, be alert to conflicting objectives and confidentiality issues. Consult a colleague, refer a patient or transfer care as needed.	Professionalism	Treatment
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Screening and early detection of mental health problems

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When patients present for care, either during periodic health examinations or opportunistically, a) Assess mental health and alcohol and substance use, as these issues are prevalent and often undetected b) Identify patients who may be at higher risk of mental health issues c) Screen those patients systematically, using validated tools as necessary	<i>Clinical Reasoning</i>	<i>History</i>
2 In a patient presenting with new or ill-defined symptoms or a change in behaviour or level of functioning, assess mental health, and alcohol and substance use.	<i>Clinical Reasoning</i>	<i>History</i>
3 For patients with a history of mental health problems or disordered alcohol or substance use, look for relapse or reoccurrence, as these are chronic diseases.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
4 For all patients with mental health or alcohol or substance use concerns, use an empathetic and non-judgemental approach to facilitate open communication.	<i>Communication</i> <i>Patient-centred Approach</i>	<i>Treatment</i> <i>Follow-up</i>
5 When following patients with mental health, and alcohol and substance use problems, ensure appropriate screening for physical problems or illness.	<i>Clinical Reasoning</i>	<i>History</i> <i>Hypothesis generation</i>

Teamwork in mental health

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When a team approach to care of a person with mental health or alcohol and substance use concerns is needed, a) Establish patient centred goals of care	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
b) Include the patient and /or the family in the creation and activities of the team	<i>Patient-centred Approach</i>	<i>Treatment</i>
c) Facilitate team membership and roles as situations evolve	<i>Professionalism</i> <i>Communication</i>	<i>Follow-up</i>
2 When sharing care of a person with mental health, alcohol or substance use concerns, a) Encourage a coordinated approach to management	<i>Professionalism</i> <i>Communication</i>	<i>Treatment</i>
b) Understand the roles and responsibilities of the team members	<i>Professionalism</i>	<i>Referral</i>
c) Establish clear and ethical communication	<i>Communication</i> <i>Professionalism</i>	<i>Treatment</i>
d) Ensure that the patient understands and agrees with these arrangements, including their own responsibilities	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
3 Anticipate the effect a team approach may have on your therapeutic alliance, and work with the patient to maintain the alliance in an appropriately modified fashion.	<i>Patient-centred Approach</i> <i>Professionalism</i>	<i>Follow-up</i>
4 When working within a team, a) Facilitate the contributions of others	<i>Professionalism</i> <i>Communication</i>	<i>Follow-up</i>
b) Use an open and respectful communication style	<i>Communication</i>	<i>Treatment</i>
c) Pay attention to careful and accurate record keeping	<i>Communication</i>	<i>Follow-up</i> <i>Treatment</i>
d) Support recovery focused care planning	<i>Clinical Reasoning</i>	<i>Treatment</i>

Trauma informed care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, with or without mental health, alcohol or substance use issues, a) Consider the possibility of undisclosed trauma b) Inquire in an empathic manner about experiences across the lifespan that may have been traumatic	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Hypothesis generation</i> <i>History</i>
2 For a patient with issues related to trauma, take the time to develop a trusting therapeutic relationship that will provide a safe space for disclosure.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i> <i>Follow-up</i>
3 For patients with a known history of trauma, adapt routine clinical encounters to avoid re-traumatizing the patient.	<i>Patient-centred Approach</i>	<i>Follow-up</i>
4 For patients with a history of trauma, reinforce their sense of autonomy and control by developing, in partnership with the patient, coping strategies and a management plan that utilize their strengths and capacities.	<i>Patient-centred Approach</i> <i>Communication</i>	<i>Treatment</i>
5 For a patient who is at risk for ongoing trauma, support the patient to develop and implement a safety plan to reduce risk.	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
6 When caring for a patient with issues related to trauma, recognize and address your own emotional responses.	<i>Professionalism</i>	<i>Treatment</i>

Using community mental health resources

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When caring for a patient with mental health and/or alcohol or substance use problems:		
a) Identify your community resources and referral pathways	<i>Professionalism</i>	<i>Treatment</i>
b) Identify those patients who could benefit from the community resources and services	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
c) Match the patient's preferences, abilities and needs to the appropriate and available resource	<i>Patient-centred Approach</i>	<i>Treatment</i>
d) Advocate to address service gaps	<i>Professionalism</i>	<i>Treatment</i>
e) Consider a full range of possible resources (e.g. recreational, occupational, spiritual etc.)	<i>Clinical Reasoning</i> <i>Patient-centred Approach</i>	<i>Treatment</i>
2 When referring to one or more community resources,		
a) Review with patient what they can expect	<i>Patient-centred Approach</i>	<i>Referral</i>
b) Facilitate access to the resources by providing necessary information and documentation	<i>Communication</i> <i>Professionalism</i>	<i>Referral</i>
c) Communicate directly with the resources when appropriate	<i>Communication</i> <i>Professionalism</i>	<i>Follow-up</i>
3 When a patient has been referred to or is being cared for by other community resources, follow up to maintain your ongoing therapeutic relationship. Ensure that the expected care is being provided.	<i>Professionalism</i>	<i>Follow-up</i>

Core Procedures

Integumentary Procedures

Abscess incision and drainage
Wound debridement
Insertion of sutures; simple, mattress, and subcuticular
Laceration repair; suture and gluing
Skin biopsy; shave, punch, and excisional
Excision of dermal lesions, e.g., papilloma, nevus, or cyst
Cryotherapy of skin lesions
Electrocautery of skin lesions
Skin scraping for fungus determination
Use of Wood's lamp
Release subungual hematoma
Drainage acute paronychia
Partial toenail removal
Wedge excision for ingrown toenail
Removal of foreign body, e.g., fish hook, splinter, or glass
Pare skin callus

Local Anesthetic Procedures

Infiltration of local anesthetic
Digital block in finger or toe

Eye Procedures

Instillation of fluorescein
Slit lamp examination
Removal of corneal or conjunctival foreign body
Application of eye patch

Ear Procedures

Removal of cerumen
Removal of foreign body

Nose Procedures

Removal of foreign body
Cautery for anterior epistaxis
Anterior nasal packing

Gastrointestinal Procedures

Nasogastric tube insertion
Fecal occult blood testing
Anoscopy/proctoscopy
Incise and drain thrombosed external hemorrhoid

Genitourinary and Women's Health Procedures

Placement of transurethral catheter
Cryotherapy or chemical therapy genital warts
Aspirate breast cyst
Pap smear
Diaphragm fitting and insertion
Insertion of intrauterine device
Endometrial aspiration biopsy

Obstetrical Procedures

Normal vaginal delivery
Episiotomy and repair
Artificial rupture of membranes

Musculoskeletal Procedures

Splinting of injured extremities
Application of sling—upper extremity
Reduction of dislocated finger
Reduce dislocated radial head (pulled elbow)
Reduce dislocated shoulder
Application of forearm cast
Application of ulnar gutter splint
Application of scaphoid cast
Application of below-knee cast
Aspiration and injection, knee joint
Aspiration and injection, shoulder joint
Injection of lateral epicondyle (tennis elbow)
Aspiration and injection of bursae, e.g., patellar, subacromial

Resuscitation Procedures

Oral airway insertion
Bag-and-mask ventilation
Endotracheal intubation
Cardiac defibrillation

Injections and Cannulations

Intramuscular injection
Subcutaneous injection
Intradermal injection
Venipuncture
Peripheral intravenous line; adult and child
Peripheral venous access—infant
Adult lumbar puncture

